STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Post Acute	521 Lorel Way Yuba City, CA 95991

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to ensure that six out of 22 sampled residents (Residents 40, 46, 90, 100, 101, and 106) was treated with dignity and respect when: 1. Facility staff did not speak English in front of Residents 46, 90, and 100. 2. The night shift was loud. 3. Resident 101 was not provided privacy during personal care. 4. Resident 40 was instructed to clean her own toilet. This had the potential for residents to not have their right for dignity, respect, and negatively impact resident's physical, mental, and psychosocial wellbeing. Findings: 1. A review of the undated document titled English Only Rule, indicated, it was the facility's policy that staff only spoke English . in resident rooms . and in any area of the facility that a resident could hear staff speaking. The English Only Rule, indicated, a violation of this policy was a violation of resident rights and that when staff signed the document, they understood, speaking in a language the resident did not understand could cause fear, confusion, and disturb residents. A review of the facility's policy and procedure (P&P) titled Resident Rights, revised 12/1/21, indicated, Employees shall treat all residents with kindness, respect, and dignity. A review of the Resident Council (an organized group of residents that met regularly to discuss and address concerns regarding their rights) meeting notes, dated 7/23/24, indicated, residents of the facility voiced concerns when facility staff did not speak English in their rooms, the hallways, and at the nurse's station. A review of the Resident Compliment or Concern document, dated 7/23/24, indicated, the Director of Staff Development (DSD) provided education to facility staff regarding the facility policy for speaking English and the issue was resolved on 8/7/24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 46's undated Admission Record, indicated, admission to the facility on [DATE] with the diagnoses of anxiety and type 2 diabetes (inability to regulate blood sugar levels because the body didn't produce enough insulin). Resident 46 was her own responsible party (RP, made own decisions). A review of Resident 46's Quarterly Minimum Data Set (MDS, an assessment tool), dated 9/17/24, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) had been performed. Resident 46 had a BIMS of 15, which indicated good memory. During an interview on 10/2/24 at 8:38 am, Resident 46 stated, staff spoke their native language in front of the residents. Resident 46 stated, when a group of staff (two or more that included Certified Nurse Assistants [CNA], Licensed Nurses [LN], or housekeepers) came into the room to provide care, they did not speak English in front of us. Resident 46 stated, I feel like they are talking about us, It bothers me, and I don't feel comfortable. A review of the undated Admissions Record, indicated Resident 90 was admitted to the facility on [DATE] with the diagnoses of type 2 diabetes and high blood pressure. Resident 90 was his own RP. A review of Resident 90's Quarterly MDS, dated [DATE], indicated, Resident 90 had good cognition and a BIMS score of 15. During an interview on 10/2/24 at 10:03 am, Resident 90 stated, when there were groups of staff in the room, hallway, or in front of other residents, they did not speak English. Resident 90 stated, during the morning, a group of female staff members were talking in the hallway, speaking their native language, and turned their backs to Resident 90 and would look back towards Resident 90. Resident 90 stated, I know they talk about me, it was frustrating and disrespectful. A review of Resident 100's undated Admissions Record, indicated, admission to the facility on [DATE] with the diagnoses of heart failure and depression. Resident 100 was her own RP. A review of Resident 100's Quarterly MDS, dated [DATE], indicated, Resident 100 had good cognition and a BIMS score of 15. During an interview on 10/1/24 at 11:34 am, Resident 100 stated, facility staff spoke in their native language in front of Resident 100 and her roommate. During an interview on 10/3/24 at 2:52 pm, the facility's Administrator (Admin) confirmed there were ongoing issues with facility staff not speaking English in front of the residents. 2. A review of the Resident Council meeting notes, dated 7/23/24, indicated, residents of the facility voiced concerns that the staff who worked the night shift was loud at the nurse's station and during shift change. A review of the Resident Compliment or Concern document, dated 7/23/24, indicated, the DSD provided education to facility staff regarding the noise level at night and the issue was resolved on 8/7/24. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/24 at 11:34 am, Resident 100 stated the facility's staff were loud at night. A review of the undated Admission Record, indicated, Resident 106 was admitted to the facility on [DATE] with the diagnosis of dysphagia following nontraumatic intracerebral hemorrhage (bleeding in the brain that caused difficulty with swallowing and was not caused by injury). Resident 106 was not her own RP (did not make own decisions). During an interview on 10/1/24 at 12:35 pm, Resident 106 stated, I feel worthless and began to cry. Resident 106 stated, I am not sleeping well and it was loud in the facility. Resident 106's family member (FM) was present and stated, it is very loud on the night shift. During an interview on 10/3/24 at 2:52 pm, Admin confirmed, there were ongoing noise concerns on the night shift. Admin stated, this morning when coming into the facility, Admin was required to tell facility staff to quiet down due to an increase in noise and reminded staff that residents were sleeping. 43755 3. A review of the facility's policy titled Resident Rights and Dignity revised February 2021, indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. A review of Resident 101's Admission Record dated 5/28/24, indicated Resident 101 was admitted to the facility on [DATE] with diagnoses that included stroke (blood flow to the brain is blocked and some brain cells die causing disabilities), muscle weakness, difficulty in walking, and major depressive disorder. A review of Resident 101's Quarterly MDS dated [DATE], indicated Resident 101's BIMS score was 07, indicating Resident 101's cognition was severely impaired. Resident 101's Functional Abilities and Goals assessment indicated Resident 101 required maximal assistance from staff for going to the bathroom, upper and lower body dressing, putting on and taking off his footwear, and transferring from a bed to wheelchair (w/c) and back to bed. During an observation on 10/1/24 at 11:48 am, Resident 101 was observed in his room sitting in his w/c wearing only a white tee shirt and briefs (a type of underwear used for incontinence [leakage of urine and bowel]). Resident 101 was attempting to put on his long pants which were on the floor in front of him. He was leaning forward in his w/c reaching to the floor with his right hand. He had the waist band in his hand and was struggling to pull the pants on which were stuck on his feet. During an observation on 10/1/24 at 11:50 am, Resident 101 was observed in his room. CNA D entered Resident 101's room and without providing privacy and in full view of the hallway and his roommates, CNA D stood Resident 101 up, exposing his briefs and bare legs, and pulled up his pants. During an interview on 10/1/24 at 11:57 am, CNA D acknowledged he had not provided privacy when he assisted Resident 101 to get dressed and he should have, but he forgot. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/24 at 11:59 am, Resident 101 indicated he had to dress himself a lot and he felt disrespected when he would be dressed out in the middle of the room without the curtain pulled around him. During an interview on 10/3/24 at 3:06 pm, the DSD indicated it was her expectations for staff to provide privacy by drawing the privacy curtain or closing the door when they are doing personal cares. 49418 4. A review of Patient-Residents' Rights: Abuse-Neglect and The Elder Justice Act Inservice, signed by Housekeeper (HSK) A and dated 8/28/19, indicated the purpose of the in-service was to educate employees to residents' rights, resident abuse, and the obligation to report suspected crimes under the Federal Elder Justice Act. The record indicated residents have the right to be free from abuse and to receive consideration, dignity, and respect in treatment and care. A review of records indicated Resident 40 was admitted in February 2024 with diagnoses of diabetes, epilepsy (seizure disorder), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder. Resident 40's MDS indicated Resident 40 had a BIMS score of 15 on 8/23/24, indicating no cognitive (mental function) impairment. During concurrent observation and interview with Resident 40 in their room on 10/1/24 at 2:58 pm, Resident 40 stated, HSK A slams the mop on the floor and hits my bed at 7 am with the mop and wakes me up. Resident 40 stated, I have to clean my own toilet. Resident 40 stated, I do get paranoid and think, 'Oh no, they don't like me.' Resident 40 stated she had had an episode of diarrhea a while ago, and feces got on the outside of the toilet. Resident 40 stated HSK A, who spoke limited English, came to her room, pointed to the toilet, then pointed at Resident 40 and handed her paper napkins to clean it. Observation together of Resident 40's bathroom indicated a commode (portable toilet) seat with handles placed over the top of the toilet (allows resident to sit higher over the toilet, decreasing the risk for fall). Resident 40 stated HSK A had pointed to the commode indicating Resident 40 was to move the commode to clean the feces. Resident 40 attempted to demonstrate how she moved the commode, became unsteady, and stopped. She stated, It's heavy, and I didn't feel well that day from my stomachache and diarrhea. During an interview with Housekeeping Manager (HSK M) on 10/3/24 at 8:43 am, HSK M stated Resident 40 told her, [HSK A] doesn't like me and hits the bed when mopping. HSK M stated Resident 40 complained about HSK A to CNA J and Resident 40 said to ask [CNA J]. HSK M stated she switched HSK A's assignment, and HSK A would not be going into Resident 40's room. During an interview with HSK A and HSK M on 10/3/24 at 8:56 am using phone translation services, HSK A stated she has worked at the facility for [AGE] years, works four days a week, and is assigned to clean Resident 40's room approximately twice weekly. HSK A began crying and stated, I never made a mistake like this before. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview with Admin and CNA J in Admin's office on 10/3/24 at 9:32 am, CNA J stated Resident 40 informed her months ago (CNA J could not remember the date) that HSK A wanted Resident 40 to clean the toilet using toilet paper. CNA J stated, [Resident 40] is afraid of [HSK A]. CNA J stated she spoke with HSK A after the incident and told HSK A it was not the resident's job to clean the toilet. CNA J stated, [HSK A] said she would not do that again. CNA J stated she did not report the incident to anyone. After CNA J hung up the phone, Admin acknowledged CNA J should have reported the incident immediately. Admin stated she would qualify the outcome of the incident as emotional distress for Resident 40. A review of 5-Day Investigation by Admin, dated 10/8/24, indicated Resident 40 informed Admin the incident occurred in 3/2024 (six months ago).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to ensure two of 22 (Resident 35 and 40) residents were free from abuse and the potential for ongoing abuse when: 1. Certified Nursing Assistant (CNA) E grabbed and held Resident 35's arm when attempting to do personal cares and CNA E continued to be assigned to Resident 35's room after the incident. 2. Housekeeper (HSK) A made Resident 40 clean her own toilet that had feces on it. HSK A continued to be assigned to clean Resident 40's room. This failure caused emotional distress and mental anguish for Resident 35 and Resident 40. Findings: A review of the State Operations Manual (SOM) revised 2/3/23, indicated abuse is defined as the willful (to act deliberately) infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. A review of the facility's policy titled Resident Rights Revised December 2021, indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. be free from abuse A review of the facility's job description titled Certified Nursing Assistant Job Duties and Responsibilities (undated), indicated to Report all allegations of resident abuse And to Honor the resident's refusal of treatment request and report to your supervisor. A review of the facility's policy titled Abuse Prevention Program revised December 2016, indicated As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff 6. Identify and assess all possible incidents of abuse; 8. Protect residents during abuse investigations. 1. A review of Resident 35's Admission Record dated 8/27/24, indicated he was readmitted on [DATE] with the diagnoses that included lung disease, depression, left sided paralysis (unable to move his left arm and leg), adult failure to thrive (the feeling of wanting to give up on life), colostomy (a surgical procedure that redirects the colon to an opening in the abdominal wall in which the feces will exit into a bag), and an indwelling urethral catheter (a tube that goes into the bladder and drains the urine into a collection bag). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 35's Admission Minimum Data Sheet (MDS, a standardized assessment of an adult's functional, medical, psychosocial, and cognitive status) dated 9/19/24, indicated Resident 35's Brief Interview for Mental Status (BIMS, evaluates a person's cognition, [ability to think, learn, remember, use judgement, and make decisions] with scores from 00 to 15) score was 15 indicating his cognition was intact and he could make his own decisions. Resident 35's level of functioning assessment indicated Resident 35 required full help from staff with toileting hygiene (the ability to clean the bottom after going to the bathroom, adjust clothes before and after urinating or having a bowel movement. If managing an ostomy, include wiping the opening.), upper and lower body dressing, and mobility (moving from his back to his left side or his right). During an observation and interview on 10/1/24 at 2:57 pm, Resident 35 was observed lying in bed with many items (iPad, papers, and other items) on his over bed table and on his bed. Resident 35 stated He (CNA E) grabbed me, he held me down because I took a swing at him. He was messing with my stuff. He was touching my iPad to move it. He would not listen to how I told him to do it. He (CNA E) still comes in my room and leaves the lights on. He is doing it on purpose. I told my nurse about it Resident 35 indicted he was distressed and upset and did not want CNA E to come in his room and was told by a nurse that CNA E would not be coming in this room anymore, but he still was. During an interview on 10/2/24 at 3:40 pm, CNA H indicated that Resident 35 had told him about a staff member that had held him down and was messing with his iPad. During an interview on 10/2/24 at 3:53 pm, the Assistant Director of Nursing (ADON) indicated there had been no report or investigation of a CNA holding down Resident 35. During an interview with the Administrator (Admin) on 10/2/24 at 3:56 pm, the Admin indicated she had not heard of any CNA holding down Resident 35. During an interview with the Admin and CNA E on 10/2/24 at 4:04 pm, CNA E stated I went to check his (Resident 35's) colostomy bag and when I was moving his over bed table, his iPad and other items, he got verbally aggressive and started whacking me. I grabbed his wrist. I should not have grabbed his arm. The second he was getting verbally aggressive I should have left and got the nurse, but I thought I could deescalate the situation. Resident 35 has always been verbally aggressive to me. CNA E indicated that he had notified a charge nurse (unknown) and the Infection Preventionist (IP). CNA E indicated he was told they would switch his resident assignment but that they had not, and he continued being assigned to Resident 35's room. CNA E indicated he had to ask other CNAs to care for Resident 35, but he would still go in the room and care for the other two residents. CNA E indicated that there was one night shift that he had to care for Resident 35 because no other staff member would switch residents with him, and Resident 35 yelled at him. The Admin indicated she was unaware of the incident and had been out of the facility on leave for about 2 weeks in September. During an interview with the IP on 10/2/24 at 4:20 pm, the IP confirmed that CNA E told her that Resident 35 was being aggressive, and she informed him to tell his charge nurse. During an interview with the Director of Staff Development (DSD) on 10/2/24 at 4:25 pm, the DSD confirmed that CNA E had told her about the incident with Resident 35. DSD indicated the incident happened on 9/15/24 during the night shift. DSD indicated she informed the Staffing Coordinator (SC) to change CNA E's assignment. DSD confirmed that there should have been an investigation into this event but there had not been. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's assignment sheets dated 9/15/24 thru 10/1/24, CNA E was assigned to care for Resident 35 on 9/15/24, 9/24/24 thru 9/27/24, 9/30/24, 10/1/24. During an interview on 10/2/24 at 4:33 pm, SC confirmed CNA E was assigned to care for Resident 35 after the incident and he should not have been. 49418 2. A review of records indicated Resident 40 was admitted in February 2024 with diagnoses of diabetes, epilepsy (seizure disorder), paranoid schizophrenia (a mental illness characterized by disturbances in thought), and anxiety disorder. The MDS indicated Resident 40 had a BIMS score of 15 on 8/23/24, indicating no cognitive (mental function) impairment. MDS also indicated Resident 40's mood was feeling down, depressed, or hopeless two to six days over the last two weeks. During concurrent observation and interview with Resident 40 in their room on 10/1/24 at 2:58 pm, Resident 40 stated HSK A slams the mop on the floor and hits my bed at 7 am with the mop and wakes me up, and, I have to clean my own toilet. Resident 40 stated she had had an episode of diarrhea a while ago, and feces was on the outside of the toilet. Resident 40 stated HSK A, who spoke limited English, came to her room, pointed to the toilet, then pointed at Resident 40 and handed her paper napkins to clean the feces. Observation of Resident 40's bathroom indicated a commode (portable toilet) seat with handles placed over the top of the toilet (allows resident to sit higher over the toilet, decreasing the risk for fall). Resident 40 stated HSK A pointed to the commode indicating Resident 40 was to move the commode to clean the feces. Resident 40 attempted to demonstrate how she moved the commode, became unsteady, and stopped. Resident 40 stated, It's heavy, and I didn't feel well that day from my stomachache and diarrhea. Resident 40 stated she told Family Member B (FM B) about the incident, and FM B brought bottles of Lysol to clean the bathroom. Two bottles of Lysol were observed in Resident 40's closet with one bottle on a shelf outside the bathroom door. Resident 40 stated, I do get paranoid and think, 'Oh no, they don't like me.' During an interview with Housekeeping Manager (HSK M) on 10/3/24 at 8:43 am, HSK M stated Resident 40 informed her, [HSK A] doesn't like me and hits the bed with the mop pole when mopping. Resident 40 informed HSK M she had complained about HSK A to Certified Nurse Assistant J (CNA J) and said to Ask [CNA J]. HSK M stated she changed HSK A's assignment, and HSK A would not be going into Resident 40's room while the incident was being investigated. During an interview with HSK A and HSK M on 10/3/24 at 8:56 am, using phone translation services, HSK A stated she had worked at the facility for [AGE] years, worked four days a week, and cleaned Resident 40's room when I'm assigned there, approximately twice weekly. HSK A began crying and stated, I never made a mistake like this before. During a phone interview with Admin and CNA J in Admin's office on 10/3/24 at 9:32 am, CNA J stated Resident 40 informed her months ago (did not remember the date) that HSK A wanted Resident 40 to clean the toilet using toilet paper. CNA J stated, [Resident 40] is afraid of [HSK A]. CNA J stated she spoke with HSK A and told HSK A it was her job to clean the toilet, and HSK A said she would not do that again. CNA J stated she did not report the incident to anyone. Admin acknowledged CNA J should have reported the incident to her for investigation. Admin stated she would qualify the outcome as emotional distress for Resident 40. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review the facility failed to report suspicions and allegations of abuse for three out of five sampled residents (Residents 22, 35, and 40) when: 1. Certified Nurse Assistant (CNA) M did not report suspicions of abuse when CNA M noticed Resident 22 showed fear during care. 2. CNA J did not report an allegation made by Resident 40 that the Housekeeper (HSK) A instructed Resident 40 to clean her own toilet. 3. Facility staff did not report an allegation of staff to resident physical abuse, when CNA E held down Resident 35. The failure to report abuse suspicions and allegations had the potential for residents' to be at risk for staff to resident abuse and had the potential to cause psychosocial harm and negatively impact the resident's overall wellbeing. Findings: A review of the facility's policy and procedures (P&P) titled, Abuse Prevention Program, revised 12/1/16, indicated, the facility would .report any allegations of abuse within timeframes as required by federal requirements. A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation revised September 2022, the policy indicated All reports of resident abuse .are reported to local, state and federal agencies and thoroughly investigated by facility management. 1. A review of the undated Admission Record, indicated, Resident 22 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (memory loss), chronic pain, and depression. Resident 22 was not her own responsible party (RP, decision maker). A review of Resident 22's Annual Minimum Data Set (MDS, an assessment tool), dated 8/27/24, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) had been performed. Resident 22 had a BIMS of 8, which indicated Resident 22's memory was moderately impaired. A review of Resident 100's undated Admissions Record, indicated, admission to the facility on [DATE] with the diagnoses of heart failure and depression. Resident 100 was her own RP. A review of Resident 100's Quarterly MDS, dated [DATE], indicated, Resident 100 had good cognition and a BIMS score of 15. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/24 at 11:34 am, Resident 22 stated, the CNAs that worked the night shift handled Resident 22 roughly when providing personal care (repositioning, providing incontinence care). Resident 100 (Resident 22's roommate) stated, witnessing CNAs handle Resident 22 in a rough manner while providing care. During an interview on 10/3/24 at 11:12 am, CNA M stated, Resident 22 had not voiced concerns regarding CNAs being rough during care. CNA M stated, Resident 22 appeared afraid while CNA M had provided personal care in the past and this was a new behavior. CNA M stated, Resident 22 had chronic pain and there was a difference between being afraid of care and having pain during care. CNA M confirmed, having suspicions of potential abuse due to Resident 22's change in behaviors and did not report it to anyone. During an interview on 10/3/24 at 2:42 pm, the facility's Administrator (Admin) stated, when staff suspected abuse, it should be reported and confirmed it was not. 49418 2. A review of records indicated Resident 40 was admitted in February 2024 with diagnoses of diabetes, epilepsy (seizure disorder), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety disorder. A review of MDS, dated [DATE], indicated Resident 40 had a BIMS score of 15, indicating no cognitive (mental function) impairment. During concurrent observation and interview with Resident 40 in their room on 10/1/24 at 2:58 pm, Resident 40 stated Housekeeper A (HSK A) slams the mop on the floor and hits my bed at 7 am with the mop and wakes me up, and, I have to clean my own toilet. Resident 40 stated she had had an episode of diarrhea a while ago, and feces was on the outside of the toilet. Resident 40 stated HSK A, who spoke limited English, came to her room, pointed to the toilet, then pointed at Resident 40 and handed her paper napkins to clean the feces. During an interview with Housekeeping Manager (HSK M) on 10/3/24 at 8:43 am, HSK M stated Resident 40 informed her, [HSK A] doesn't like me and hits the bed with the mop pole when mopping. Resident 40 informed HSK M she had complained about HSK A to Certified Nurse Assistant J (CNA J) and said to Ask [CNA J]. During a phone interview with Admin and CNA J in Admin's office on 10/3/24 at 9:32 am, CNA J stated Resident 40 informed her months ago (did not remember the date) that HSK A wanted Resident 40 to clean the toilet using toilet paper. CNA J stated, [Resident 40] is afraid of [HSK A]. CNA J stated she spoke with HSK A and told HSK A it was her job to clean the toilet, and HSK A said she would not do that again. CNA J stated she did not report the incident to anyone. Admin acknowledged CNA J should have reported the incident to her for investigation. Admin stated she would qualify the outcome as emotional distress for Resident 40. During an interview with Admin on 10/3/24 at 12:47 pm, Admin stated she spoke with Resident 40, who informed her the incident occurred in March. Admin stated she called CNA J back to ask when she spoke to the housekeeper; CNA J stated she didn't remember, it was so long ago. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 40 on 10/3/24 at 2:44 pm, Resident 40 smiled, said Thank you, and stated she was so happy she had a new housekeeper clean her room today. During an interview with HSK M on 10/8/24 at 11:20 am, HSK M stated the Housekeeping company will investigate the abuse allegation. HSK M stated HSK A was suspended pending investigation results, and she was awaiting Admin's paperwork. A review of CNA Job Description, dated 2003, indicated CNAs report all incidents observed on the shift that they occur . report all complaints and grievances made by the resident to the Nurse Supervisor/Charge Nurse . and report all allegations of resident abuse. 43755 3. A review of Resident 35's Admission Record dated 8/27/24, indicated he was readmitted on [DATE] with the diagnoses that included lung disease, depression, left sided paralysis (unable to move his left arm and leg), adult failure to thrive (the feeling of wanting to give up on life), colostomy (a surgical procedure that redirects the colon to an opening in the abdominal wall in which the bowel will exit into a bag), and an indwelling urethral catheter (a tube that goes into the bladder and drains the urine into a collection bag). A review of Resident 35's Admission MDS dated [DATE], indicated Resident 35's BIMS score was 15 indicating his cognition was intact and he could make his own decisions. Resident 35's level of functioning assessment indicated Resident 35 required full help from staff with toileting hygiene (the ability to clean the bottom after going to the bathroom, adjust clothes before and after urinating or having a bowel movement. If managing an ostomy, include wiping the opening.), upper and lower body dressing, and mobility (moving from his back to his left side or his right). During an observation and interview on 10/1/24 at 2:57 pm, Resident 35 was observed lying in bed with many items (iPad, papers, and other items) on his over bed table and on his bed. Resident 35 stated He (CNA E) grabbed me, he held me down because I took a swing at him. He was messing with my stuff. He was touching my iPad to move it. He would not listen to how I told him to do it. He (CNA E) still comes in my room and leaves the lights on. He is doing it on purpose. I told my nurse about it Resident 35 indicted he was distressed and upset and did not want CNA E to come in his room and was told by a nurse that CNA E would not be coming in this room anymore, but he still was. During an interview on 10/2/24 at 3:53 pm, the Assistant Director of Nursing (ADON) indicated there had been no report or investigation of a CNA holding down Resident 35 During an interview with the Admin on 10/2/24 at 3:56 pm, the Admin indicated she had not heard of any CNA holding down Resident 35. During an interview with CNA E and Admin on 10/2/24 at 4:04 pm, CNA E confirmed that he had grabbed Resident's arm while trying to perform cares and he should not have. He indicated that he told the Infection Preventionist (IP) and a charge nurse. The Admin confirmed there was no investigation or report to the local state or federal agencies and there should have been. During an interview with the IP on 10/2/24 at 4:20 pm, the IP confirmed that CNA E told her that Resident 35 was being aggressive, and she informed him to tell his charge nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Staff Development (DSD) on 10/2/24 at 4:25 pm, the DSD confirmed that CNA E had told her about the incident with Resident 35. DSD indicated the incident happened on 9/15/24 during the night shift. DSD indicated she informed the Staffing Coordinator (SC) to change CNA E's assignment. DSD confirmed that there should have been an investigation into this event but there had not been.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on interview and record review, the facility failed to ensure allegations of abuse for three out of five sampled residents (Residents 22, 35, and 40) were investigated and residents were protected during this process when: 1. Certified Nurse Assistant (CNA) M did not report suspicions of abuse when CNA M noticed Resident 22 showed fear during care. 2. CNA J did not report an allegation made by Resident 40 that the Housekeeper (HSK) A instructed Resident 40 to clean her own toilet. 3. When facility staff did not report an allegation of staff to resident physical abuse, when CNA E held down Resident 35. This placed all residents at risk for staff to resident abuse and had the potential for physical and psychosocial harm. Findings: A review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, indicated, suspicion and allegations of abuse would be investigated, and residents would be protected from further abuse during the investigation. A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation revised September 2022, the policy indicated All reports of resident abuse .are reported to local, state and federal agencies and thoroughly investigated by facility management. 1. A review of the undated Admission Record, indicated, Resident 22 was admitted to the facility on [DATE] with the diagnoses of Alzheimer's Disease (memory loss), chronic pain, and depression. Resident 22 was not her own responsible party (RP, decision maker). A review of Resident 22's Annual Minimum Data Set (MDS, an assessment tool), dated 8/27/24, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) had been performed. Resident 22 had a BIMS of 8, which indicated Resident 22's memory was moderately impaired. A review of Resident 100's undated Admissions Record, indicated, admission to the facility on [DATE] with the diagnoses of heart failure and depression. Resident 100 was her own RP. A review of Resident 100's Quarterly MDS, dated [DATE], indicated, Resident 100 had good cognition and a BIMS score of 15. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/24 at 11:34 am, Resident 22 stated, the CNAs that worked the night shift handled Resident 22 roughly when providing personal care (repositioning, providing incontinence care). Resident 100 (Resident 22's roommate) stated, witnessing CNAs handle Resident 22 in a rough manner while providing care. During an interview on 10/3/24 at 11:12 am, CNA M stated, Resident 22 had not voiced concerns regarding CNAs being rough during care. CNA M stated, Resident 22 appeared afraid while CNA M had provided personal care in the past and this was a new behavior. CNA M stated, Resident 22 had chronic pain and there was a difference between being afraid of care and having pain during care. CNA M confirmed, having suspicions of potential abuse due to Resident 22's change in behaviors (becoming fearful) and did not report it to anyone. During an interview on 10/3/24 at 2:42 pm, the facility's Administrator (Admin) confirmed, when staff suspected abuse, it should be reported and investigated, and it was not. 49418 2. A review of records indicated Resident 40 was admitted in February 2024 with diagnoses of diabetes, epilepsy (seizure disorder), paranoid schizophrenia (a mental illness characterized by disturbances in thought), and anxiety disorder. A review of MDS, dated [DATE], indicated Resident 40 had a BIMS score of 15, indicating no cognitive (mental function) impairment. During concurrent observation and interview with Resident 40 in their room on 10/1/24 at 2:58 pm, Resident 40 stated Housekeeper A (HSK A) slams the mop on the floor and hits my bed at 7 am with the mop and wakes me up, and, I have to clean my own toilet. Resident 40 stated she had had an episode of diarrhea a while ago, and feces was on the outside of the toilet. Resident 40 stated HSK A, who spoke limited English, came to her room, pointed to the toilet, then pointed at Resident 40 and handed her paper napkins to clean the feces. During an interview with Housekeeping Manager (HSK M) on 10/3/24 at 8:43 am, HSK M stated Resident 40 informed her, [HSK A] doesn't like me and hits the bed with the mop pole when mopping. Resident 40 informed HSK M she had complained about HSK A to Certified Nurse Assistant J (CNA J) and told HSK M to Ask [CNA J]. During a phone interview with Administrator (Admin) and CNA J in Admin's office on 10/3/24 at 9:32 am, CNA J stated Resident 40 informed her months ago (did not remember the date) that HSK A wanted Resident 40 to clean the toilet using toilet paper. CNA J stated, [Resident 40] is afraid of [HSK A]. CNA J stated she spoke with HSK A and told HSK A it was her job to clean the toilet, and HSK A said she would not do that again. CNA J stated she did not report the incident to anyone. Admin acknowledged CNA J should have reported the incident to her for investigation. Admin stated she would qualify the outcome as emotional distress for Resident 40. During an interview with Admin on 10/3/24 at 12:47 pm, Admin stated she had spoken with Resident 40, who informed her the incident occurred in March 2024 (six months ago). Admin stated she called CNA J back to ask when she spoke to the housekeeper, but CNA J stated she didn't remember, It was so long ago. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 40 on 10/3/24 at 2:44 pm, Resident 40 smiled, said Thank you, and stated she was so happy she had a new housekeeper clean her room today. During an interview with HSK M on 10/8/24 at 11:20 am, HSK M stated the housekeeping company will investigate the abuse allegation. HSK M stated HSK A was suspended pending investigation results, and she was awaiting Admin's paperwork. 43755 3. A review of Resident 35's Admission Record dated 8/27/24, indicated he was readmitted on [DATE] with the diagnoses that included lung disease, depression, left sided paralysis (unable to move his left arm and leg), adult failure to thrive (the feeling of wanting to give up on life), colostomy (a surgical procedure that redirects the colon to an opening in the abdominal wall in which the bowel will exit into a bag), and an indwelling urethral catheter (a tube that goes into the bladder and drains the urine into a collection bag). A review of Resident 35's Admission Minimum Data Sheet (MDS, a standardized assessment of an adult's functional, medical, psychosocial, and cognitive status) dated 9/19/24, indicated Resident 35's Brief Interview for Mental Status (BIMS, evaluates a person's cognition, [ability to think, learn, remember, use judgement, and make decisions] with scores from 00 to 15) score was 15 indicating his cognition was intact and he could make his own decisions. Resident 35's level of functioning assessment indicated Resident 35 required full help from staff with toileting hygiene (the ability to clean the bottom after going to the bathroom, adjust clothes before and after urinating or having a bowel movement. If managing an ostomy, include wiping the opening.), upper and lower body dressing, and mobility (moving from his back to his left side or his right). During an observation and interview on 10/1/24 at 2:57 pm, Resident 35 was observed lying in bed with many items (iPad, papers, and other items) on his over bed table and on his bed. Resident 35 stated He (CNA E) grabbed me, he held me down because I took a swing at him. He was messing with my stuff. He was touching my iPad to move it. He would not listen to how I told him to do it. He (CNA E) still comes in my room and leaves the lights on. He is doing it on purpose. I told my nurse about it Resident 35 indicted he was distressed and upset and did not want CNA E to come in his room and was told by a nurse that CNA E would not be coming in this room anymore, but he still was. During an interview on 10/2/24 at 3:40 pm, CNA H indicated that Resident 35 had told him about a staff member that had held him down and was messing with his iPad. During an interview on 10/2/24 at 3:53 pm, the Assistant Director of Nursing (ADON) indicated there had been no report or investigation of a CNA holding down Resident 35 During an interview with the Administrator (Admin) on 10/2/24 at 3:56 pm, the Admin indicated she had not heard of any CNA holding down Resident 35. During an interview with CNA E and Admin on 10/2/24 at 4:04 pm, CNA E confirmed that he had grabbed Resident's arm while trying to perform cares and he should not have. He indicated that he told the Infection Preventionist (IP) and a charge nurse. The Admin confirmed there was no investigation or report to the local state or federal agencies and there should have been. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056346	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Post Acute	521 Lorel Way Yuba City, CA 95991

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the IP on 10/2/24 at 4:20 pm, the IP confirmed that CNA E told her that Resident 35 was being aggressive, and she informed him to tell his charge nurse. She indicated she had not followed up on this. During an interview with the Director of Staff Development (DSD) on 10/2/24 at 4:25 pm, the DSD confirmed that CNA E had told her about the incident with Resident 35. DSD indicated the incident happened on 9/15/24 during the night shift. DSD indicated she informed the Staffing Coordinator (SC) to change CNA E's assignment. DSD confirmed that there should have been an investigation into this event but there had not been. During a review of the facility's assignment sheets dated 9/15/24 thru 10/1/24, CNA E was assigned to care for Resident 35 on 9/15/24, 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/30/24, 10/1/24. During an interview on 10/2/24 at 4:33 pm, SC confirmed CNA E was assigned to care for Resident 35 after the incident and he should not have been.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview, and record review, the facility failed to ensure accurate and complete documentation for one of three closed records reviewed when Resident 112 was transferred to an acute care hospital and the facility did not document the date and time of their transfer, where they transferred to, how they were transported, or the disposition of their personal effects and medications. This failure had the potential to negatively impact Resident 112's continuity of care and had the potential risk of them receiving inadequate care or services. Findings: During a review of the facility's policy, titled, Transfer or Discharge Documentation, no revised date provided, indicated: - When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. - When a resident is transferred or discharged from the facility, the following information will be documented in the medial record: a. The basis for the transfer or discharge; b. That an appropriate notice was provided to the resident and /or legal representative; c. The date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medial, physical, and mental conditions; g. Disposition of personal effects; h. Others as appropriate or as necessary; and i. The signature of the person recording the data in the medical record. During a review of Resident 112's clinical record, indicted that Resident 112 was admitted to the facility on [DATE] with diagnoses which included right hip joint replacement surgery, anxiety, and depression. Resident 112 was their own healthcare decision maker. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 112's clinical record, titled, Change in Condition Assessment/SBAR [Situation, Background, Appearance, and Review], dated 7/17/24 at 3:12 pm, indicated that Resident 112 had a change in condition, pain on the right hip and swollen as per resident and assessed by the licensed nurse MD [Medical Director] and RP [Responsible Party] made aware. Pain meds administered as ordered During a concurrent interview and record review on 10/4/24, at 11:42 am, the Director of Nurses (DON) confirmed Resident 112's clinical record did not contain a nursing progress note for transfer to the hospital. The DON further confirmed the nursing progress note was not completed to indicate when resident 112 was transferred to the hospital, how they were transferred or which hospital they were transferred to. The DON stated the documentation should have been completed, the DON said, if the resident was sent out to the hospital, the nursing progress note would have assessment, intervention, and the order of the doctor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on observation, interview, and record review, the facility failed to ensure one of 23 (Resident 101) residents had non-skid footwear on to prevent falls as per his care plan. The facility's lack of safety intervention for Resident 101 had the potential for injury related to unwitnessed falls. Findings: A review of Resident 101's Admission Record dated 5/28/24, indicated Resident 101 was admitted to the facility on [DATE] with diagnoses that included stroke (blood flow to the brain is blocked and some brain cells die causing disabilities), muscle weakness, difficulty in walking, and major depressive disorder. A review of Resident 101's Quarterly Minimum Data Set (MDS, a standardized assessment of an adult's functional, medical, psychosocial, and cognitive status) dated 9/4/24, indicated Resident 101's Brief Interview for Mental Status (BIMS, evaluates a person's cognition, [ability to think, learn, remember, use judgement, and make decisions] with scores from 00 to15) score was 07, indicating Resident 101's cognition was severely impaired. Resident 101's Functional Abilities and Goals assessment indicated Resident 101 required maximal assistance from staff for going to the bathroom, upper and lower body dressing, putting on and taking off his footwear, and transferring from a bed to wheelchair (w/c) and back to bed. A review of Resident 101's Fall Care Plan, dated 5/29/24, indicated Resident was at risk for falls related to weakness, poor balance, poor endurance, diagnoses, and history of falls prior to admission. Interventions initiated were to be sure Resident 101's call light was within reach. Anticipate and meet Resident 101's needs. Ensure that Resident 101 was wearing appropriate footwear when out of bed or mobilizing in his wheelchair. During an observation on 10/1/24 at 11:48 am, Resident 101 was observed in his room sitting in his wheelchair wearing only a white tee shirt and briefs (a type of underwear used for incontinence [leakage of urine and bowel]). Resident 101 was attempting to put on his long pants which were on the floor in front of him. He was leaning forward in his wheelchair reaching to the floor with his right hand. He had the waist band in his hand and was struggling to pull the pants on which were stuck on his feet. Resident 101 was in his bare feet. Resident's call light was on the floor. During an observation on 10/1/24 at 11:50 am, Resident 101 was observed in his room. Certified Nursing Assistant (CNA) D entered Resident 101's room and assisted Resident 101 with pulling up his pants. CNA D left the room without putting shoes or socks on Resident 101. During an interview on 10/1/24 at 11:57 am, CNA D acknowledged Resident 101 should have shoes on, but that Resident 101 was not assigned to him that day. CNA D indicated the CNA assigned to Resident 101 was on her brake and when Resident 101 was trying to stand up earlier he went into the room and helped Resident 101 into his chair but did not get him ready for the day because it was not his resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Post Acute	521 Lorel Way Yuba City, CA 95991

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/1/24 at 11:59 pm, Resident 101 was observed lying in his bed with his pants on backwards and in his bare feet. Resident 101's call light was on the floor. Resident 101 indicated it was hard to find his call light and that he had to dress himself a lot. Resident 101 indicated he liked to get ready for the day and to have shoes and socks on. Resident 101 indicated he remembered a time he was trying to get up by himself to get ready for the day and he fell and banged his head, and everything hurt. During an interview on 10/3/24 at 3:06 pm, the Director of Staff Development (DSD) indicated Resident 101 should have on non-skid socks or shoes to prevent falls.

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F 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45315

Based on interview and record review, the facility failed to provide appropriate care for two out of three sampled residents (Residents 87 and 214) with a gastrostomy tube (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) when:

1. Licensed Nurses (LN) did not follow Resident 87's Physician orders regarding g-tube feeding (Physician prescribed liquid nutrition [formula/feedings] amounts, hydration (free water provided for hydration), water flushes (water flushes aide in keeping the g-tube unclogged and maintained), and inaccurately documented intake amounts.

2. For Resident 87, LNs provided g-tube care without a Physician's order and did not document the care that was provided.

3. Resident 214 received an excessive amount of fluids.

These failures placed g-tube residents at risk for fluid overload (too much fluid that placed residents at risk for choking), g-tube malfunction, and had the potential for a decline in health status that could result in hospitalization .

Findings:

1. A review of the facility's undated policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump, indicated, Licensed Nurses would review the Physician's order prior to administering g-tube feeding and document the amount of g-tube feeding and water flushes that were provided.

A review of the undated Admission Record, indicated, Resident 87 was admitted to the facility on [DATE] with the diagnoses of malignant neoplasm of tonsil (a type of head and neck cancer), gastrostomy status (g-tube), and dysphagia, oropharyngeal phase (swallowing problems). Resident 87 was his own responsible party (RP, decision maker).

A review of Resident 87's Quarterly Minimum Data Set (MDS, an assessment tool), dated 7/8/24, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) had been performed. Resident 87 had a BIMS of 15, which indicated Resident 87's memory was intact.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/8/24 at 2:58 pm, with LN O Resident 87's Physician's Order (also titled order details), dated 9/24/24, was reviewed along with the Medication Administration Record (MAR), dated 10/1/24 through 10/8/24. LN O stated, the Physician's Order indicated, Resident 87 would receive a total of 2,525 milliliters (ml, unit of measure) of total water intake (amount taken in) from the g-tube feeding and water flushes over a 24-hour period. LN O reviewed the MAR and stated, the MAR indicated, Resident 87 would also receive a 30 ml water flush before and after each medication administration. LN O stated, Resident 87 received medications one time on the am shift for a total of 60 ml of water flushes, two times on the pm shift for a total 120 ml of water flushes, and one time on the night shift for a total of 60 ml of water flushes (a total combined intake total for a 24-hour period, based on Physician orders, was 2,765 ml of g-tube feeding and water). LN O stated, the MAR indicated, Resident 87 received 30 ml of water flushes on each shift and the documentation was incorrectly recorded. LN O stated the documentation for water flushes should have indicated Resident 87 received 120 ml on the pm shift and 60 ml on the am and night shift. LN O reviewed the MAR and stated, the MAR indicated, on 10/1/24, 10/3/24 through 10/5/24, and 10/7/24, LNs documented Resident 87 received, 3,600 ml in a 24-hour period (a total of 835 ml extra fluid), on 10/2/24, Resident 87 received 2,525 ml in a 24-hour period (240 ml less than the Physician ordered), and on 10/6/24, LNs did not document the 24-hour intake total. LN O confirmed, the 24-hour intake totals and the water flush totals did not match the Physician's Order and LNs did not document water flushes correctly. During a concurrent interview and record review on 10/8/24 at 3:57 pm, the Registered Dietician (RD) reviewed the Physician's Order, dated 9/24/24 and stated, the Physician's Order indicated, Resident 87 received 100 ml of tube feeding an hour over 22 hours and the total water volume from the g-tube feeding and the additional water flushes, equaled 2,525 ml. During a concurrent interview and record review on 10/8/24 at 4:11 pm, RD and Director of Nurses (DON) reviewed Resident 87's MAR dated 10/1/24 through 10/8/24. RD and DON confirmed the above calculations regarding Resident 87's total intake, derived from g-tube feedings, water flushes, and water flushes provided before and after medication administration. The RD and the DON confirmed, LN had not been following the Physician's orders and stated, LN had provided too little or too much g-tube feeding. RD and DON confirmed, the above totals for G-tube water flushes, before and after administrations, and stated the MAR indicated LNs were flushing with 30 ml of water with each medication pass and not the Physician ordered 60ml. 2. A review of the facility's undated policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump, indicated, LNs would assess the g-tube site for placement (placing a puff of air into the stomach through the g-tube and listening to hear the sound) prior to administering g-tube feeding and document the assessment. A review of the facility's P&P titled Checking Gastric Residual Volume (GRV), revised 11/1/18. Indicated, LNs would ensure there was a Physician's order prior to checking g-tube residuals (stomach contents) and document the amount of residual if any. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/8/24 at 2:58 pm, Resident 87's Physician Orders, dated 4/1/24 through 10/8/24 was reviewed. LN O stated, prior to administering g-tube feeing, LN O would always check for g-tube placement and residuals. LN O was asked where LN O documented LN O's assessment regarding g-tube placement and residuals. LN O stated, LN O did not document when LN O checked the g-tube for placement or residuals. LN O reviewed Physician's Orders, and stated, the order to check for residuals and g-tube placement was entered into the system, today, 10/8/24. LN O confirmed, LN O had been checking g-tube placement and residuals prior to 10/8/24 without a Physician's Order. During an interview on 10/8/24 at 4:11 pm, DON confirmed there was no order prior to 10/8/24 for LN to check Resident 87's g-tube placement or check for residuals and there should have been. 43755 2. A review of the facility's policy titled Enteral Nutrition (a way of sending nutrition/food directly to the stomach thru a G-Tube) revised November 2018, indicated 3. The dietitian, with input from the provider and nurse: a. estimates calorie, protein, nutrient, and fluid needs. d. Calculates fluids to be provided (beyond free fluids in formula). 11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include . g. instructions for flushing (solution, volume, frequency, timing and 24-hour volume) A Review of Resident 214's Admission Record dated 9/16/24, indicated Resident 214 was initially admitted on [DATE], after a hospital stay was readmitted to the facility on [DATE]. Resident 214's diagnoses included Hemiplegia and Hemiparesis (unable to move his left side) following a stroke (blood is blocked from getting to the brain causing cell death), dysphagia (difficulty swallowing), aphasia (difficulty with talking), cognitive communication deficit. A review of Residents 214's 5-day (a review of the first five days in the facility) MDS dated [DATE], indicated his BIMS was 5, indicating Resident 214's cognition was severely impaired. A review of Resident 214's Discharge Summaries Notes from the hospital, dated 9/16/24, indicated orders: Correction diet: Glucerna 1.2 (liquid formula nutrition) at 60 mL an hour. Free water 300 mL every 4 hours. Keep head of the bed elevated more than 30 degrees at all times. Aspiration (fluid or food going into the lungs) precautions. A review of Resident 214's Medical Nutritional Therapy Assessment Recommendations by the Registered Dietitian (RD) dated 9/18/24, indicated recommendations were to change the 9/16/24 order to: 1. Add NPO (nothing by mouth) for diet. 2. Glucerna 1.2 at rate of 75mL an hour x 20 hours to provide 1500 mL of formula, 1800 kcal (kilocalories, measurement of energy), 90 g (grams, a measurement) protein, and 1207 mL free water (the amount of water in the formula). Water flushes 150 mL every 4 hours to provide 900 mL to equal 2107 mL of total water. A review of Resident 214's Physician Order Summary indicated: * An order dated 9/16/24 for Every 4 hours give free water 300 ml. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*An order dated 9/18/24 to administer enteral formula every shift: Glucerna 1.2 at a rate of 75 ml an hour, stop at 10:00 am and start at 2:00 pm to provide 1500 mL formula, 1800 kcal, 90 g protein and 1207 ml free water. Water flushes 150 mL every 4 hours to provide 900mL to equal 2107 mL total water (in 24 hours). A review of Resident 214's Medication Administration Record for the month of October 2024, indicated total water ordered for the day was 3907 mL. Which included: *An order for water flushes 300 mL every 4 hours to equal 1800 mL of water. *An order for water flushes 150 mL every 4 hours to equal 900 mL of water *An order for the free water from the formula equaling 1207 mL. A review of Resident 214's progress notes dated 10/7/24 at 6:25 pm, Licensed Nurse (LN) O documented upon assessment found G-Tube formula leaking from tubing Resident sent to ER (emergency room) for further evaluation A review of Resident 214's ER Physician notes dated 10/8/24 at 2:11 am, indicated a target volume (amount of fluid Resident 214 should get in one day) of less than 30 mL/kg (kg a measurement of weight) was to be given due to concern for fluid overload. According to the ER record, Resident 214's weight in the ER was 77. 11 kg which would equal 2313.3 mL of fluid in one day. A review of Resident 214's ER visit dated 10/8/24 at 2:34 am, by Supervising Physician (SP) indicated the nurse noticed that the formula was coming out of the patients' mouth, he was coughing and gagging. Assessment of Resident 214 by the SP was aspiration pneumonia (pneumonitis, inflammation of lungs, due to inhalation of food and vomit). During an interview and record review with the RD on 10/8/24 12:26 pm, Resident 214's October 2024 MAR and Physician Orders were reviewed. The RD confirmed Resident 214 was getting over the amount of 2107 mL of water she had recommended. The RD was unaware Resident 214 was getting 3907mL of fluid. The RD indicated Resident 214's admission orders for 300 mL water flushes every 4 hours had not gotten discontinued and it should have been. The RD indicated she usually reviews the orders, but she must have missed this one. During an interview on 10/8/24 12:40 pm, Nurse Practitioner (NP) indicated that 3907 mL was excessive amount of fluid to give Resident 214. NP stated, Yes he is getting too much fluid. During an interview on 10/8/24 at 12:42 pm, the Assistant Director of Nursing (ADON) confirmed that Resident 214 was getting over his recommended amount of water and indicated the order for 300 mL of water every four hours should have been discontinued and it was not.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview and record review, the facility failed to ensure physician progress notes (doctor's note about resident progress, care, and medical issues) were complete, signed and dated at each visit for for two of four sampled residents (Resident 34, and 98). This failure had the potential to negatively affect communication between disciplines and to result in inappropriate care and service for the residents. Findings: During a review of the facility's job description, titled, Medical Director (MD), revised 10/20, indicated that the MD's duties and responsibilities which included: - Interview residents to obtain history, perform physical examination, order labs, and other tests, prescribe medications and treatments as part of the plan of care. - Provide routine medical care for residents as necessary. - Ensure residents attain or maintain their highest practical physical, mental and psychosocial well-being. During a review of Resident 34's clinical record, indicated that Resident 34 was initially admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). Resident 34 was not his own healthcare decision maker. During a review of Resident 34's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 7/29/24, indicated Resident 34's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. During a review of Resident 98's clinical record, indicated that Resident 98 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD, also known as kidney failure, is a terminal illness that occurs when the kidneys can no longer function properly), benign neoplasm (benign tumor) on right eyelid, and dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally.) He was his own healthcare decision maker. During a review of Resident 98's MDS, dated [DATE], indicated Resident 98's cognition was intact. During a concurrent observation and interview on 10/1/24 at 11:26 am with Resident 98, Resident 98 's right eye was covered with a gauze. Resident 98 stated, I had been here for over a month, I was waiting for my eye's surgery, they missed it 3 times, and the doctor never came to see me . (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/24 at 11:30 am with Resident 34, Resident 34 stated, I had been here for 2 years, had never seen the doctor . During a concurrent interview and record review on 10/3/24 at 11:11 am with the Director of Nursing (DON), Resident 34 and 98's clinical record was reviewed. The DON confirmed that she could only locate one physician note for Resident 98, and the note was incomplete, there was no date, no assessment of Resident 98's right eye. The DON also confirmed that there was no physician note in 6/2024, and 9/2024 for Resident 34. The DON stated, I can never read/understand MD's handwritten note. During a concurrent interview and record review on 10/3/24 at 11:15 am with the Medical Record Assistant (MRA), the MRA stated that MD was no longer with the facility, started the end of September 24. MRA stated, our last medical provider had not completed his note, the most recent one was done in 7/2024 We knew the doctor, he did not date, and his note/assessment was not always true, and accurate .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview, and record review the facility failed to ensure nursing staff demonstrated appropriate skill sets that were required to care for *** out of 22 sampled residents when: 1. Licensed Nurses (LN) did not reassess, notify the Physician, or follow up on Resident 98's potentially infected right eye. 2. LNs and Certified Nurse Assistants (CNA) did not report suspicions or allegations of abuse for Residents 22, 35, and 40. (Refer to F609) 3. LN did not adequately monitor gastrostomy tube (g-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) feedings (liquid hydrations provided through the g-tube) and provided care without a Physician's order. (Refer to F693) 4. LNs did not thoroughly check meal trays to ensure residents received the appropriate food. (Refer to F800) These failures had the potential for hospitalization , and could negatively impact resident's physical, mental, and psychosocial wellbeing. Findings: During a review of the facility's policy, titled, Competency of Nursing staff, revised 5/19, indicated that, Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: - Preventing abuse, neglect, and exploitation of resident property. - Dementia management. - Resident rights. - Person centered care. - Communication. - Basic nursing skills. - Basic restorative services. - Skin and wound care. - Pain management. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Infection control - Identification of change in condition - Cultural competency. During a review of the facility's job description, titled, Licensed Practical (Vocational) Nurse (LPN)/(LVN), revised 5/22, indicated that the primary purpose of this position is to provide nursing care to the residents under the supervision of a physician and/or registered nurse and within the scope of nursing practice for the state. Their duties and responsibilities included: - Facilitate physician rounds by preparing carts, flagging areas of concern, and preparing physician orders for signature, document physician visits with residents. - Report any suspicion of a crime that may have been committed to a resident in the facility. - Perform administrative duties by completing medical forms, reports, evaluations, studies, charting, etc. - Assist with resident meals, including delivering meals and helping residents who need help with feeding, as needed. - Provide nursing care that is compassionate and sensitive to residents with cognitive decline, memory loss or history of trauma. - Provide nursing care that is appropriate and sensitive to the culture, language, and background of the resident. - Maintain documentation of all nursing care and services provided to the residents; use nurse's notes, flow sheets and electronic medical records according to facility protocol. - Monitor the skin health of the resident; provide preventative skin care; administer wound treatment as ordered. During a review of the facility's job description, titled, Registered Nurse (RN), revised 5/22, indicated that the primary purpose of this position is to provide nursing care to the residents under the medical direction of the residents' attending physician and within the scope of nursing practice for the state. Their duties and responsibilities included: - Provide oversight of Certified Nursing Assistants (CNAs) and Licensed Nurse (LN) as directed by the Director of Nursing. - Facilitate physician rounds by preparing carts, flagging areas of concern, and preparing physician orders for signature, document physician visits with residents. - Report any suspicion of a crime that may have been committed to a resident in the facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Perform administrative duties by completing medical forms, reports, evaluations, studies, charting, etc. - Provide nursing services to residents in accordance with scope of practice, facility policies, and professional standards of care. - Monitor the chronic health conditions of residents; be familiar with reportable changes and potential causes for concern. - Provide nursing care that is compassionate and sensitive to residents with cognitive decline, memory loss or history of trauma. - Provide nursing care that is appropriate and sensitive to the culture, language, and background of the resident. - Maintain documentation of all nursing care and services provided to the residents; use nurse's notes, flow sheets and electronic medical records according to facility protocol. 1. During a review of Resident 98's clinical record, indicated that Resident 98 was admitted on [DATE] with diagnoses which included end stage renal disease (ESRD, also known as kidney failure, is a terminal illness that occurs when the kidneys can no longer function properly), benign neoplasm (benign tumor) on right eyelid, and dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally.) He was his own healthcare decision maker. During a review of Resident 98's MDS, dated [DATE], indicated Resident 98's cognition was intact. During a review of Resident 98's record, titled, Admission Skin Assessment, dated 7/30/24, at the section A - Skin, indicated that Resident 98 had Non-pressure skin conditions present, at the section C - Non-Pressure assessment, there's no note or description indicated where the location, and what the assessment was, there's only a note at the Narrative box, indicated that, Skin assessment is done by two LN. Following skin alterations are noted - Skin tear to abdomen (1x2.5 cm); Redness to eye with dressing on. Resident stated it is infected and he is already scheduled for surgery in September . During a review of Resident 98's nursing progress notes from 7/24 to 10/24, there was no note related to Resident 98's right eye to be found. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/3/24 at 11:11 am with the Director of Nursing (DON), Resident 98's admission record and nursing progress notes were reviewed. The DON confirmed that the admission LN did not assess and document the condition of Resident 98's right eye, and there was no nursing weekly progress note regarding Resident 98's eye assessment, and no note that indicated the nursing staff had notified the MD, and the Scheduler to follow up with Resident 98's right eye appointment and surgery schedule. The DON stated that she would expect the nursing weekly progress note documenting everything regarding Resident 98's right eye condition, such as any redness, discharge, swollen, any pain, was the MD notified, what the order was, etc. The DON also said, When someone had an appointment, we would have the Scheduler arranged the appointment and transportation for Resident 98. We would honor it, and the Interdisciplinary team (IDT - a gathering of healthcare providers from different disciplines to coordinate care for a patient) meeting would be discussing it. During an interview with on 10/4/24 at 3:40 pm with the Scheduler, the Scheduler stated that the nurse who did the initial assessment should have communicated with her and notified her about Resident 98's scheduled appointment for the surgery, she would try to contact the provider and arrange the transportation for the resident. 45315 2a. A review of the facility's P&P titled, Abuse Prevention Program, revised 12/1/24, indicated, allegations of abuse would be reported .within timeframes as required by federal requirements. During an interview on 10/1/24 at 11:34 am, Resident 22 stated, the CNAs that worked the night shift handled Resident 22 roughly when providing personal care (repositioning, providing incontinence care). Resident 100 (Resident 22's roommate) stated, witnessing CNAs handle Resident 22 in a rough manner while providing care. During an interview on 10/3/24 at 11:12 am, CNA M stated, Resident 22 had not voiced concerns regarding CNAs being rough during care. CNA M stated, Resident 22 appeared afraid while CNA M had provided personal care in the past and this was a new behavior. CNA M stated, Resident 22 had chronic pain and there was a difference between being afraid of care and having pain during care. CNA M confirmed, having suspicions of potential abuse due to Resident 22's change in behaviors and did not report it to anyone. During an interview on 10/3/24 at 2:42 pm, the facility's Administrator (Admin) stated, when staff suspected abuse, it should be reported and confirmed it was not. 2b. A review of Patient-Residents' Rights: Abuse-Neglect and The Elder Justice Act Inservice, signed by Housekeeper (HSK) A and dated 8/28/19, indicated the purpose of the inservice was to educate employees to residents' rights, resident abuse, and the obligation to report suspected crimes under the Federal Elder Justice Act. The record indicated residents have the right to be free from abuse and to receive consideration, dignity, and respect in treatment and care. A review of records indicated Resident 40 was admitted in February 2024 with diagnoses of diabetes, epilepsy (seizure disorder), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder. Resident 40's MDS indicated Resident 40 had a BIMS score of 15 on 8/23/24, indicating no cognitive (mental function) impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER: Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 521 Lorel Way Yuba City, CA 95991	

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent observation and interview with Resident 40 in their room on 10/1/24 at 2:58 pm, Resident 40 stated, HSK A slams the mop on the floor and hits my bed at 7 am with the mop and wakes me up. Resident 40 stated, I have to clean my own toilet. Resident 40 stated, I do get paranoid and think, 'Oh no, they don't like me.' Resident 40 stated she had had an episode of diarrhea a while ago, and feces got on the outside of the toilet. Resident 40 stated HSK A, who spoke limited English, came to her room, pointed to the toilet, then pointed at Resident 40 and handed her paper napkins to clean it. Observation together of Resident 40's bathroom indicated a commode (portable toilet) seat with handles placed over the top of the toilet (allows resident to sit higher over the toilet, decreasing the risk for fall). Resident 40 stated HSK A had pointed to the commode indicating Resident 40 was to move the commode to clean the feces. Resident 40 attempted to demonstrate how she moved the commode, became unsteady, and stopped. She stated, It's heavy, and I didn't feel well that day from my stomachache and diarrhea. During an interview with Housekeeping Manager (HSK M) on 10/3/24 at 8:43 am, HSK M stated Resident 40 told her, [HSK A] doesn't like me and hits the bed when mopping. HSK M stated Resident 40 complained about HSK A to CNA J and Resident 40 said to ask [CNA J]. HSK M stated she switched HSK A's assignment, and HSK A would not be going into Resident 40's room. During an interview with HSK A and HSK M on 10/3/24 at 8:56 am using phone translation services, HSK A stated she has worked at the facility for [AGE] years, works four days a week, and is assigned to clean Resident 40's room approximately twice weekly. HSK A began crying and stated, I never made a mistake like this before. During a phone interview with Admin and CNA J in Admin's office on 10/3/24 at 9:32 am, CNA J stated Resident 40 informed her months ago (CNA J could not remember the date) that HSK A wanted Resident 40 to clean the toilet using toilet paper. CNA J stated, [Resident 40] is afraid of [HSK A]. CNA J stated she spoke with HSK A after the incident and told HSK A it was not the resident's job to clean the toilet. CNA J stated, [HSK A] said she would not do that again. CNA J stated she did not report the incident to anyone. After CNA J hung up the phone, Admin acknowledged CNA J should have reported the incident immediately. Admin stated she would qualify the outcome of the incident as emotional distress for Resident 40. A review of 5-Day Investigation by Admin, dated 10/8/24, indicated Resident 40 informed Admin the incident occurred in 3/2024 (six months ago). 2c. A review of records indicated Resident 40 was admitted in February 2024 with diagnoses of diabetes, epilepsy (seizure disorder), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety disorder. A review of MDS, dated [DATE], indicated Resident 40 had a BIMS score of 15, indicating no cognitive (mental function) impairment. During concurrent observation and interview with Resident 40 in her room on 10/1/24 at 2:58 pm, Resident 40 stated Housekeeper A (HSK A) slams the mop on the floor and hits my bed at 7 am with the mop and wakes me up, and, I have to clean my own toilet. Resident 40 stated she had had an episode of diarrhea a while ago, and feces was on the outside of the toilet. Resident 40 stated HSK A, who spoke limited English, came to her room, pointed to the toilet, then pointed at Resident 40 and handed her paper napkins to clean the feces. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Housekeeping Manager (HSK M) on 10/3/24 at 8:43 am, HSK M stated Resident 40 informed her, [HSK A] doesn't like me and hits the bed with the mop pole when mopping. Resident 40 informed HSK M she had complained about HSK A to Certified Nurse Assistant J (CNA J) and said to Ask [CNA J]. During a phone interview with the Administrator (Admin) and CNA J in Admin's office on 10/3/24 at 9:32 am, CNA J stated Resident 40 informed her months ago (did not remember the date) that HSK A wanted Resident 40 to clean the toilet using toilet paper. CNA J stated, [Resident 40] is afraid of [HSK A]. CNA J stated she spoke with HSK A and told HSK A it was her job to clean the toilet, and HSK A said she would not do that again. CNA J stated she did not report the incident to anyone. Admin acknowledged CNA J should have reported the incident to her for investigation. Admin stated she would qualify the outcome as emotional distress for Resident 40. During an interview with Admin on 10/3/24 at 12:47 pm, Admin stated she spoke with Resident 40, who informed her the incident occurred in March. Admin stated she called CNA J back to ask when she spoke to the housekeeper; CNA J stated she didn't remember, it was so long ago. During an interview with Resident 40 on 10/3/24 at 2:44 pm, Resident 40 smiled, said Thank you, and stated she was so happy she had a new housekeeper clean her room today. A review of CNA Job Description, dated 2003, indicated CNAs report all incidents observed on the shift that they occur . report all complaints and grievances made by the resident to the Nurse Supervisor/Charge Nurse . and report all allegations of resident abuse. A review of CNA/Home Health Aide (HHA) In-Service Training/Continuing Education Units (CEUs), dated 1/26/23 to 1/26/25, indicated CNA J received the following trainings: Your Legal Duty (1/31/24), What is Abuse? (2/1/24), Privacy and Dignity (4/3/24), Preventing Abuse (4/30/24), Abuse and Neglect (8/14/24), and Abuse: Resident to Resident (7/25/24, 8/27/24). 3. A review of the facility's undated policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump, indicated, Licensed Nurses would review the Physician's order prior to administering g-tube feeding. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review on 10/8/24 at 2:58 pm, with LN O Resident 87's Physician's Order (also titled order details), dated 9/24/24, was reviewed along with the Medication Administration Record (MAR), dated 10/1/24 through 10/8/24. LN O stated, the Physician's Order indicated, Resident 87 would receive a total of 2,525 milliliters (ml, unit of measure) of total water intake (amount taken in) from the g-tube feeding and water flushes over a 24-hour period. LN O reviewed the MAR and stated, the MAR indicated, Resident 87 would also receive a 30 ml water flush before and after each medication administration. LN O stated, Resident 87 received medications one time on the am shift for a total of 60 ml of water flushes, two times on the pm shift for a total 120 ml of water flushes, and one time on the night shift for a total of 60 ml of water flushes (a total combined intake total for a 24-hour period, based on Physician orders, was 2,765 ml of g-tube feeding and water). LN O stated, the MAR indicated, Resident 87 received 30 ml of water flushes on each shift and the documentation was incorrectly recorded. LN O stated the documentation for water flushes should have indicated Resident 87 received 120 ml on the pm shift and 60 ml on the am and night shift. LN O reviewed the MAR and stated, the MAR indicated, on 10/1/24, 10/3/24 through 10/5/24, and 10/7/24, LNs documented Resident 87 received, 3,600 ml in a 24-hour period (a total of 835 ml extra fluid), on 10/2/24, Resident 87 received 2,525 ml in a 24-hour period (240 ml less than the Physician ordered), and on 10/6/24, LNs did not document the 24-hour intake total. LN O confirmed, the 24-hour intake totals and the water flush totals did not match the Physician's Order and LNs did not document water flushes correctly. LN O was observed reviewing the g-tube feeding totals on the machine (feeding pump) that provided Resident 87 his g-tube feedings. LN O was asked if the feeding pump had the ability to show a history of when the feeding pump was last cleared. LN O stated unawareness and while accessing the screen that indicated how much feeding had been administered, the total was over 3,000 ml. LN O pushed a button and the screen cleared, and stated LN O was unaware of what happened. LN O stated, prior to administering g-tube feeing, LN O would always check for g-tube placement and residuals. LN O was asked where LN O documented LN O's assessment regarding g-tube placement and residuals. LN O stated, LN O did not document when LN O checked the g-tube for placement or residuals. LN O reviewed Physician's Orders, and stated, the order to check for residuals and g-tube placement was entered into the system, today, 10/8/24. LN O confirmed, LN O had been checking g-tube placement and residuals prior to 10/8/24 without a Physician's Order. During a concurrent interview and record review on 10/8/24 at 3:57 pm, the Registered Dietician (RD) reviewed the Physician's Order, dated 9/24/24 and stated, the Physician's Order indicated, Resident 87 received 100 ml of tube feeding an hour over 22 hours and the total water volume from the g-tube feeding and the additional water flushes, equaled 2,525 ml. During a concurrent interview and record review on 10/8/24 at 4:11 pm, RD and Director of Nurses (DON) reviewed Resident 87's MAR dated 10/1/24 through 10/8/24. RD and DON confirmed the above calculations regarding Resident 87's total intake, derived from g-tube feedings, water flushes, and water flushes provided before and after medication administration. The RD and the DON confirmed, LN had not been following the Physician's orders and stated, LN had provided too little or too much g-tube feeding. RD and DON confirmed, the above totals for G-tube water flushes, before and after administrations, and stated the MAR indicated LNs were flushing with 30 ml of water with each medication pass and not the Physician ordered 60ml. (continued on next page)

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	056346	A. Building B. Wing	10/08/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Dining and Food Preferences, revised 9/1/17, indicated, resident food preferences would be reviewed, documented, and an alternate meal substitution would be provided. 4. A review of the job duties, titled, Registered Nurse and Licensed Practical (Vocational) Nurse (LPN)/(LVN), revised 5/1/22, indicated, the facility's LN would oversee the CNAs as directed. During an interview on 10/1/24 at 1:25 pm, the facility's Infection Preventionist (IP) stated, when the resident meal trays arrived to the unit, the LN were responsible for checking the resident meal trays prior to the CNA serving the meal to the residents to ensure the meal contained the appropriate diet, utensils, and LN would observe the meal to ensure the food served was not listed on the resident's dislike list. During a concurrent observation and interview, on 10/3/24 at 8:31 am, located in Resident 106's room, there was no breakfast tray present. Resident 106 stated, I was served an egg and cheese omelet this morning and they know I don't like eggs, so I didn't eat it. Certified Nurse Assistant (CNA) B arrived and provided Resident 106 with an alternate breakfast. When CNA B removed the lid from the plate, a piece of bacon and an egg and cheese omelet was observed. CNA B stated unawareness that Resident 106 did not like eggs, CNA B walked to the breakfast tray cart and found Resident 106's original breakfast tray, observed an egg and cheese omelet on the plate, and reviewed the meal tray ticket. CNA B confirmed, the meal tray ticket indicated, Resident 106 disliked eggs, was provided an egg and cheese omelet for breakfast, and the alternate meal provided, consisted of an egg and cheese omelet. During an interview on 10/3/24 at 8:50 am, Licensed Nurse (LN) C stated, the LNs were responsible for performing a visual inspection of the meal trays prior to Certified Nurse Assistant (CNA) serving the residents their meals. LN C stated, the reason the LN's checked the meal trays was to ensure residents received the correct meal texture, the correct adaptive equipment (utensils, plates, cups), and that the meal did not include foods that the resident did not like. LN C stated, being responsible for checking Resident 106's breakfast tray and stated, LN C was in a hurry and did not review the breakfast trays for resident food preferences. LN C confirmed, Resident 106 was served an egg and cheese omelet and did not like eggs.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 The facility failed to provide medically related Social Services, that met the needs of the residents, for four out of 22 sampled residents (Residents 35, 87, 90, and 98) when: 1. Social Service care plans (a document that described resident goals and the interventions [instruction, actions, education, and care required] that facility staff would utilize to assist in residents reaching their goals) were not updated quarterly (every 3 months) or as needed for Residents 87 and 90. 2. Care conference meeting (meeting held quarterly to discuss care, needs, and goals, that included the resident, social services, nursing, activities director and the dietary department) notes did not reflect a discharge plan or discharge planning needs for Resident 90. 3. Social Services did not assist Resident 90 with financial documents when requested. 4. Outside services and referrals were not made in a timely manner for Resident 98. 5. Dental services were not provided in a timely manner for Resident 35. These failures had the potential for needs to go unmet and cause a delay in needed care which could lead to a decline in health and psychosocial wellbeing. Findings: During a review of the facility's policy, titled, Social Services, revised 10/2010, indicated the facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. The services statement indicates: - The Director of Social Services is a qualified social worker and is responsible for: a. Consultation with other departments regarding program planning, policy development, and priority setting of social services. b. An adequate record system for obtaining, recording, and filing of social service data - Medially-related social services is provided to maintain or improve each resident's ability to control everyday physical needs (e.g., appropriate adaptive equipment for eating, ambulation, etc.); and mental and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose). - Factors that have a potentially negative effect on psychosocial functioning include: a. Institutional attitudes and practices which affect the resident's dignity and sense of control. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Disability or loss of function. c. Presence of a progressive, chronic disabling condition (i.e., Multiple Sclerosis, Chronic Obstructive Pulmonary Disease, Alzheimer's disease, mental illness). d. Behavioral problems (i.e., confusion, anxiety, loneliness, depressed mood, anger, fear, wandering, psychotic episode) - The social services department is responsible for: a. Identifying individual social and emotional needs. b. Assisting in providing corrective action for the resident's needs by developing and maintaining individualized social services care plans. c. Maintaining regular progress and follow-up notes indicating the resident's response to the plan and adjustment to the institutional setting. d. Compiling and maintain up-to-date information about community health and services agencies available for resident referrals. e. Making referrals to social services agencies as necessary or appropriate. f. Maintain appropriate documentation of referrals and providing social service data summaries to such agencies. g. Making supportive visits to residents and performing needed services (i.e., communication with the family or friends, coordinating resources and services to meet the resident's needs). h. Informing the resident or representative (sponsor) of the resident's personal and property rights as well as serving on the group council to assure that complaints and grievances are promptly answered/resolved. i. Working with individuals and groups in developing supportive services for residents according to their individual needs and interests. j. Participating in interdisciplinary staff conferences, providing social service information to ensure treatment of the social and emotional needs of the resident as a part of the total plan of care. k. Participating in the planning of the resident's admission, return to home and community, or transfer to another facility by assessing the impact of these changes and making arrangements for social and emotional support . - Inquiries concerning social services should be referred to the Director of Social Services. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's job description, titled, Social Worker, revised 10/20, signed by the Social Service Director (SSD), dated 1/23/22, indicated the primary purpose of this position is to assist in implementing, evaluating and participating in the overall operation of the social services department in accordance with current federal, state, and local standards and regulations. The duties and responsibilities include: - Implement the social services programs of the facility under the direction of the Administrator and the Director of Social Services. - Participate in the facility assessment and assess individual social services needs and resources. - Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident. - Coordinate social services activities with other members of the interdisciplinary team (IDT). - Assist residents, representatives and families with seeking financial assistance, discharge planning (including collaboration with community agencies) and referrals to other community agencies. - Meet with administration, medical, and nursing staff as well as other related departments in planning social services programs and activities. - Participate in the development of a resident-centered care plan for each resident. - Involve the resident/family in planning individualized objectives and goals for the resident. - Communicate the social, psychological and emotional needs of the resident/family to other members of the IDT. - Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. - Coordinate transfer or discharges for residents. - Manage the transfers or discharges process when a resident has appealed. - [NAME] residents who are being transferred to another facility or who are being discharged ; assist residents and their resident representatives in selecting a post-discharge care provider. - Refer residents/families to appropriate social services agencies when the facility does not provide the services or needs of the residents. 1. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/1/22, indicated, the care plan would be updated quarterly. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review if the facility's P&P titles, Social Services, dated 10/1/10, indicated, social services would assist .in providing corrective action for the resident's needs by developing and maintaining individualized social services care plans. A review of the undated Admission Record, indicated, Resident 87 was admitted to the facility on [DATE] with the diagnoses of malignant neoplasm of tonsil (a type of head and neck cancer), gastrostomy status (g-tube), and dysphagia, oropharyngeal phase (swallowing problems). Resident 87 was his own responsible party (RP, decision maker). A review of Resident 87's Quarterly Minimum Data Set (MDS, an assessment tool), dated 7/8/24, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) had been performed. Resident 87 had a BIMS of 15, which indicated Resident 87's memory was intact. A review of Resident 87's Care Conference, dated 4/5/24, indicated, Resident 87's discharge plan included being transferred to a facility in Sacramento because he is familiar with the area and he'd be closer to his mom, who is on hospice. During a concurrent interview and record review on 10/4/24 at 9:33 am, with SSD, Resident 87's discharge care plan, dated 4/9/24, was reviewed. SSD stated, Resident 87 was admitted to the facility for short term care and wanted to transfer to a facility in the Sacramento area to be closer to his mom. SSD stated care plans were updated quarterly and as needed. SSD confirmed, Resident 87's care plan indicated Resident 87 was admitted for long term care (not short-term care), was not updated quarterly or as needed, and did not reflect Resident 87's desire to transfer back to the Sacramento area and should have. A review of the undated Admissions Record, indicated Resident 90 was admitted to the facility on [DATE] with the diagnoses of type 2 diabetes and high blood pressure. Resident 90 was his own RP. A review of Resident 90's Quarterly MDS, dated [DATE], indicated, Resident 90 had a BIMS of 15 and Resident 90's memory was intact. A review of Resident 90's Care Conference, dated 1/28/24, indicated Resident 90's discharge plan was uncertain. A review of Resident 90's discharge care plan, dated 2/1/24, indicated Resident 90 was admitted to the facility for a short-term stay. There was no care plan update noted. During a concurrent interview and record review on 10/3/24 at 2:52 pm, the facility's Administrator (ADMIN) stated, discharge planning started upon admission to the facility and that care plans were updated quarterly. ADMIN reviewed Residents 87 and 90's care plan. ADMIN confirmed, SSD had not updated the care plans quarterly to reflect the discharge plan and should have. 2. A review of the Social Worker job description, dated 1/23/22, indicated, the Social Services Director (SSD) would Assist residents, representatives and families with seeking financial assistance, discharge planning . and referrals to other community agencies. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review if the facility's P&P titles, Social Services, dated 10/1/10, indicated, social services participated in the planning of assisting residents during the discharge process and maintained social services documentation. During an interview on 10/2/24 at 10:03 am, Resident 90 stated, that Resident 90 needed assistance with finding housing and a care giver so that Resident 90 could be discharged from the facility. Resident 90 stated, the SSD would not assist with a discharge plan. During a concurrent interview and record review on 10/3/24 at 12:56 pm, SSD stated, discharge planning started once the resident was admitted to the facility. SSD reviewed Resident 90's Care Conference meeting note, dated 1/28/24, and stated the meeting note indicated, Resident 90's discharge plan was uncertain. SSD stated, there was no discharge plan because Resident 90 had nowhere to go. SSD stated, maybe there was a breakdown in communication and was unaware that Resident 90 wanted to discharge because Resident 90 had not vocalized wanted to be discharged . During a concurrent interview and record review on 10/3/24 at 2:52 pm, with ADMIN, Resident 90's Care Conference meeting notes, dated 4/3/24 and 7/29/24 were reviewed. ADMIN confirmed, the meeting notes did not include information from SSD regarding a discharge plan and should have. 3. A review if the facility's P&P titles, Social Services, dated 10/1/10, indicated, social services assisted residents with financial needs or problems. During an interview on 10/2/24 at 10:03 am, Resident 90 stated, that Resident 90 needed assistance with obtaining an income so that Resident 90 could be discharged . Resident 90 stated, asking SSD for assistance with disability paperwork and the SSD told Resident 90 there were things the SSD did not do. During an interview on 10/3/24 at 12:56 pm, SSD stated, Resident 90 did not have a discharge plan and did not have any money. SSD stated, SSD did not know disability paperwork and SSD spoke with Adult Protective Services to assist Resident 90 with applying for disability. During an interview on 10/3/24 at 2:52 pm, ADMIN stated, SSD was expected to assist residents with finances and SSD should have assisted Resident 90 with disability paperwork. 43739 4. During a review of Resident 98's clinical record, indicated that Resident 98 was admitted on [DATE] with diagnoses which included end stage renal disease (ESRD, also known as kidney failure, is a terminal illness that occurs when the kidneys can no longer function properly), benign neoplasm (benign tumor) on right eyelid, and dependence on renal dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally.) He was his own healthcare decision maker. During a review of Resident 98's MDS, dated [DATE], indicated Resident 98's cognition was intact. During a review of Resident 98's clinical record, titled, Social Service Bundle assessments, dated 8/2/24, and 9/21/24, at the section Discharge Planning, indicated that Resident 98, right eye covered with eye patch. Resident 98 says There a bug in there and I need a procedure to fix it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 98's care plan, initiated on 8/2/24 by SSD, indicated, Resident 98 has a visual deficit and requires the use of prescription glasses. His right eye is also covered due to [Other benign Neoplasm of skin of eyelid. Including canthus (the outer or inner corner of the eye, where the upper and lower lids meet.). The interventions were to, Monitor eyes for redness, discharge, irritation, itchiness, burning, pain and swelling, and Ophthalmology or Optometry consult as needed. Or upon request. During a concurrent observation and interview on 10/1/24 at 9:37 am with Resident 98, observed Resident 98's right eye was covered with a large bandage. Resident 98 stated, I had a wart and it's growing into my eye . Resident 98 stated that he had been worried and asking about getting his surgery done ever since he was admitted to the facility, and he was worried about losing his right eye. Resident 98 stated, No one is helping me get the surgery I need. I don't want to lose my eye. I don't want to lose my vision . Resident 98 stated he couldn't sleep at night because he was worried, and he had complained multiple times, no one was helping him. Resident 98 stated he wanted to be discharged so he could take care of his eye because no one in the facility would help him. During an interview on 10/1/24 at 11:26 am with Resident 98, Resident 98 stated, I had to go out and get myself an eye doctor. I had pre-op, lab work and surgery appointments in September, the facility missed them all During a review of Resident 98's social service progress notes from 8/2/24 to 10/1/24, there's no note indicated that Resident 98 had been referral to see an ophthalmology or had been set up with the transportation to follow up with any exiting eye appointment. During an interview on 10/3/24 at 11:11 am with the Director of Nursing (DON), Resident 98's social service assessment was reviewed. The DON stated she was not made aware of Resident 98's pre exiting eye appointment until 9/30/24 when SSD informed her about Resident 98's appointment, she started making phone call. The DON stated, When someone had an appointment, we would arrange the appointment and transportation for Resident 98. We would honor it, and the Interdisciplinary team (IDT - a gathering of healthcare providers from different disciplines to coordinate care for a patient) meeting would be discussing it. During a concurrent interview and record review on 10/4/24 at 3:30 pm with the SSD, Resident 98's care plan, initiated on 8/2/24, and Social Service Assessments, dated 8/2/24, and 9/21/24, were reviewed. The SSD admitted that she initiated the care plan for Resident 98's eye, and she did not send Ophthalmology referral. The SSD also stated that she did the assessments on 8/2/24 and 9/21/24, and was aware of Resident 98's eye appointment, the SSD stated, I told the DON, it's the nursing's job to follow it up, not mine. However, the SSD was not able to provide any record indicating that she had notified the nursing staff/DON about Resident 98's eye appointments. 43755 5. A review of the Social Service job description dated 1/23/22 and signed by the SSD on 1/23/22, the job description indicated the duties and responsibilities of the SSD are to assist in obtaining resources from community, social, health and welfare agencies to meet the needs of the resident. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled Dental Examination/Assessment revised December 2013, indicated Upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist. A review of Resident 35's Admission Record dated 8/27/24, indicated he was readmitted on [DATE] with the diagnoses that included lung disease, depression, left sided paralysis (unable to move his left arm and leg), adult failure to thrive (the feeling of wanting to give up on life), colostomy (a surgical procedure that redirects the colon to an opening in the abdominal wall in which the bowel will exit into a bag), and an indwelling urethral catheter (a tube that goes into the bladder and drains the urine into a collection bag). During a concurrent observation and interview of Resident 35 on 10/1/24 at 3:02 pm, Resident 35 was observed in his room lying in bed. Resident had no teeth in his mouth. Resident 35 stated They (a dentist that came to the facility) pulled them out and now they say they cannot give them (dentures) to me because I do not have insurance. I was eating good with the teeth I had in my mouth, now I cannot chew the bread it is too hard. During an interview on 10/03/24 at 11:36 am, the SSD indicated Resident 35 had his teeth extracted on December 8, 2023, by a facility contracted dental service, and impressions and x-rays were done on January 12, 2024. During an interview on 10/3/24 at 11:37 am, the Social Service Assistant (SSA) indicated Resident 35's insurance plan had changed, and the contracted dental services will not honor the new insurance. A review of Resident 35's dental notes from (Dental Name) Healthcare dated 12/08/23, showed Resident 35 had 4 teeth extracted. A review of Resident 35's dental notes from (Dental Name) Healthcare dated 1/12/24, showed Resident 35 had upper and lower impressions taken for new dentures. A review of Resident 35's Care Conference dated 6/2/24, showed notes written by the SSD Daughter also asks that we follow up with his dentures. A review of an e-mail by Patient Care Coordinator (PCC) from (Dental Name) Healthcare dated 6/13/24, indicated I have called a couple of times to discuss a couple of patients that their denture process is on hold due to their (Insurance name). During an interview on 10/3/24 at 1:56 pm, the SSD indicated she had not called the contracted dental services to follow up on Resident 35 dentures until his daughter brought it up at the care conference 5 months after he had his teeth pulled and impressions done. The SSD indicated that she should have followed up on it.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on observation, interview, and record review, one of 22 sampled residents (Resident 61) failed to be free of unnecessary psychotropic medications when Resident 61 had a routine Ativan (anti-anxiety medication) order of 0.5 milligrams (mg - a unit of measure) and a pro re nata (PRN - as needed) order for Ativan 0.5 mg. The PRN Ativan order was available for five months without an order end date despite Consulting Pharmacist (CPH) recommendations to discontinue the PRN order or limit the order to 14 days per Centers for Medicare and Medicaid Services (CMS - a federal entity that works to improve the quality of healthcare) regulations. Psychotropic medications affect brain activities associated with mental processes and behaviors and include anti-psychotic, anti-depressant, anti-anxiety and hypnotic (sedating) medications. This deficient practice had the potential for Resident 61 to experience adverse (negative, potentially harmful) side effects from excessive or unnecessary psychotropic medications including sedation, falls, abnormal involuntary movements, stroke, and death. Findings: A review of Policy and Procedure (P&P) titled Medication Monitoring, Medication Management, dated 1/2022, indicated: 1. The facility must ensure PRN orders for psychotropic drugs are limited to 14 days, without exception. PRN orders cannot be renewed unless the attending physician directly examines the resident to determine if the antipsychotic is still needed on a PRN basis, evaluates the benefits of the medication, and determines if expressions or indications of distress are improved as a result of the PRN medication. The intent of this requirement is that PRN psychotropic medication orders are only used when the medication is necessary and PRN use is limited. 2. The facility must rule out other causes of distress such as pain and environmental factors such as staffing levels, overstimulation, and noise levels. 3. The facility assures that residents are monitored for potential adverse effects such as falls, shortness of breath, increased blood pressure, weight loss/gain, agitation, distress, tardive dyskinesia (involuntary movements), and stroke. If adverse effects are identified, the facility and prescriber must determine if the medication should be continued and document the rationale for the decision. A review of P&P titled Dementia - Clinical Protocol, dated 11/2018, indicated: 1. The physician will help identify individuals who have been diagnosed with dementia and those with otherwise impaired cognition (mental processing). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Interdisciplinary Team (IDT - a team with members from different disciplines who work together to set resident goals and make care decisions) evaluates and helps identify symptoms and findings that differentiate dementia from other causes. 3. The physician and staff will review the effectiveness and complications of medications and will adjust, stop, or change such medications as indicated. A review of records indicated Resident 61 was a [AGE] year-old admitted in March 2021 with diagnoses of alcoholic hepatitis (a life-threatening liver condition caused by heavy alcohol use), chronic kidney disease, anxiety disorder, and chronic pain. Resident 61 was later diagnosed with schizoaffective disorder - bipolar type (disrupted thoughts and perceptions, extreme mood swings) on 5/25/21, after-effects of stroke on 9/29/22, and unspecified dementia (decline in thought processes, memory, and reasoning) with psychotic disturbance on 4/24/24. The record indicated Resident 61 was unable to make their own healthcare decisions. A review of Minimum Data Set (MDS - a tool used to assess and manage care of residents in nursing homes), dated 7/7/24, indicated Resident 61's score was 8 out of 15 on Brief Interview for Mental Status (BIMS - an assessment tool to screen mental status), demonstrating moderate to severe cognitive (mental function) impairment. The MDS indicated Resident 61 had little interest in doing things and feeling down two to six days over the last two weeks. MDS indicated Resident 61 was taking antipsychotic, antianxiety, antidepressant, opioid (pain medication), and antiplatelet (prevents blood clots) medications. A review of Care Plans, printed 10/3/24, indicated: 1. Initiated 3/31/21, revised 7/16/24: Resident 61 uses Ativan for anxiety manifested by (m/b) shortness of breath and Lexapro for anxiety m/b agitation. Interventions include administering anti-anxiety medications, monitoring for side effects and effectiveness, IDT review of medications quarterly and as needed, monitoring Resident 61 for safety due to increased risk of cognitive impairment and falls, monitoring for adverse effects including aggressive or impulsive behaviors, and monitoring/recording excessive verbalization of worry. 2. Initiated 5/29/21, revised 7/16/24: Resident 61 is on Seroquel for schizoaffective disorder m/b angry aggressive behavior towards others and Rexulti for dementia with psychotic disturbance m/b episodes of agitation. Interventions include administering psychotropic medications, consult pharmacist/MD to consider dose reduction when appropriate at least quarterly, IDT to review medications quarterly and as needed, monitor for adverse effects of psychotropic medications including falls and weight loss, and monitor/record behavior symptoms of angry aggressive behavior towards others and agitation. 3. Initiated 4/5/24: Resident 61 is on Ativan related to aggressive behaviors. Interventions included administering Ativan PRN, monitoring behaviors every shift and tally, monitoring for adverse reactions/side effects of Ativan, notifying MD if worsening, and providing redirection and other non-medication interventions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Risk versus (v.) Benefits IDT Review for Gradual Dose Reduction (GDR), dated 4/24/24, indicated the Current Psychotropic Regimen included Seroquel 50 mg, two tablets by mouth twice a day, for schizophrenia as evidenced by angry aggressive behaviors towards others, and buspirone hydrochloride (anti-anxiety medication) 10 mg, 1 tablet by mouth three times a day, for anxiety disorder m/b uncontrollable motor movements. IDT recommended adding Rexulti 2 mg daily for episodes of agitation with behavior monitoring and review in one month. Ativan was not addressed in the record. A review of Consultant Pharmacist's (CPH) Medication Regimen Review by CPH A, dated 4/29/24, indicated Resident 61 had a PRN order for Ativan. CPH A documented that CMS regulations limit all PRN psychotropic medications to 14 days unless the prescriber specifies an end-date duration. CPH A recommended the prescriber discontinue PRN Ativan or add an end date to the order. A review of three records titled IDT Psychotherapeutic Tally and Review (PT&R), dated 6/17/24, 7/15/24, and 8/20/24, indicated the following: A. Behavior tallies (nursing documentation of behaviors): 1. Angry aggressive behavior towards others: March 105, April 123, May 56, June 53, July 47. 2. Verbalization of anxiousness: April 132, May 109. 3. Shortness of breath: April 132, May 109, June 57, July 50. 4. Psychotic disturbance as evidenced by agitation: April 12, May 41, June 77. 5. Verbalization of health concerns: May 41, June 84, July 78. B. The 6/17/24 IDT PT&R indicated previous recommendations and plan were to discontinue Rexulti, add escitalopram 10 mg daily for anxiety m/b agitation, and increase Seroquel to 200 mg twice a day, with review in one month. The record indicated escitalopram (antidepressant) was started 5/22/24 for depression m/b verbalization of health concerns. IDT Note and Recommendations from meeting on 6/19/24: Reviewed current tallies and medications with IDT. Plan to increase Rexulti to 3 mg, update escitalopram monitoring, and update Ativan PRN m/b to shortness of breath (SOB), with review during next psych meeting. C. The 7/15/24 IDT PT&R indicated gradual dose reduction to begin 7/17/24 for Rexulti: give 2 mg for one week, then 1 mg for one week, then discontinue. IDT Note and Recommendations from meeting on 7/17/24: Tallies and medications reviewed by IDT team. Plan to GDR Rexulti and continue other medications with no change, with review during next psych meeting. D. The 8/20/24 IDT PT&R indicated IDT Note and Recommendations from meeting on 8/28/24: Tallies and medications reviewed. No changes recommended at this time. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of CPH Medication Regimen Review by CPH A, dated 7/1/24, indicated Resident 61 was at increased risk of serotonin syndrome toxicity (a potentially life-threatening drug reaction) while on a combination of Lexapro (antidepressant), Ativan, Seroquel, and Rexulti (antipsychotic medication). The record indicated the risk of serotonin syndrome toxicity may be increased when Ativan, Seroquel, and Rexulti are administered together. CPH A recommended monitoring closely for symptoms of toxicity and consider alternatives to the current regimen. A review of two CPH Medication Regimen Reviews by CPH A, dated 8/2/24 and 8/29/24, indicated Resident 61 had a PRN order for Ativan. CPH A documented that CMS regulations limit all PRN psychotropic medication use to 14 days and cannot be continued unless the prescriber evaluates the resident for appropriateness and documents rationale for continuation. CPH A recommended the prescriber discontinue PRN Ativan or add an end date to the order. During an interview with Social Services Assistant (SSA) on 10/8/24 at 11:41 am, SSA stated Resident 61 has had four unwitnessed falls in the last two months. SSA stated Resident 61 has been more independent in a wheelchair recently, wheeling herself throughout the facility. SSA stated Resident 61 will get worked up like it's the end of the world. SSA stated yelling and calling out is present but is less. During an interview with Director of Nursing (DON) on 10/8/24 at 10:32 am, DON stated IDT psychotropic medication reviews occur the third Wednesday of each month with CPH A and CPH B. DON stated medication recommendations are received from CPH A the first week of each month for the previous month, but September wasn't done yet. DON stated this was because state survey started, and the facility had a change of medical director effective 10/1/24. DON stated IDT evaluates behaviors from nursing documentation of behavior tallies during medication regimen review, and then pharmacists and the medical director evaluate medication dosages and make changes as needed. During an interview with CNA P on 10/8/24 at 12:26 pm, CNA P stated Resident 61 has behaviors every day, but not as bad as it was, noting Resident 61 is verbally aggressive with staff. CNA P stated, [Resident 61] will ask for a pain pill. If the nurse isn't 'fast enough,' she'll call the nurse a f***ing b*tch. During an interview with CNA N on 10/8/24 at 12:48 pm, CNA N stated Resident 61 shows aggressive verbal behaviors mostly daily. CNA N stated Resident 61 will cuss you out, call you names. CNA N stated she usually tells the nurse about these behaviors but does not typically document it in the medical record because it's daily and expected behavior. During a concurrent interview with Social Services Director (SSD) and SSA and record review on 10/8/24 at 3:48 pm, SSD stated she participates in monthly Medication Regimen Reviews as part of the IDT team. SSD stated she prepares a list for review for each resident to be reviewed and confirms tallies (behavior monitor counts) are correct. SSA stated Resident 61 had anxiety on admission, was initially able to go out for smoke breaks, but then had a change to more aggressive behaviors. SSD reviewed records and stated the physician was notified 10/5/22 that Resident 61's Patient Health Questionnaire-9 (PHQ9 - a depression questionnaire) triggered for depression. SSD stated IDT had been meeting monthly for the past year to evaluate Resident 61's medication regimen. SSD stated Resident 61 is more needy now, was not like that before, and has been calling out for help now. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with CPH B and record review on 10/08/24 at 4:05 pm, CPH B stated he had been a pharmacist for [AGE] years. CPH B stated he had been the consulting pharmacist for the facility for two years when CPH A took over about a year ago. CPH B reviewed records on his computer and stated Resident 61 had a scheduled (routine) Ativan order and a PRN (as needed) Ativan order. CPH B stated the PRN Ativan 0.5 mg order was in place in 4/2024 at the time CPH A recommended the PRN order be discontinued or an order end-date be added. CPH B stated the PRN Ativan order was not discontinued until 8/12/24 (four months later). However, CPH B stated a new PRN Ativan 0.5 mg order was started the same day, 8/12/24, and was not discontinued until 9/11/24 (30 days later). CPH B acknowledged PRN Ativan was ordered for greater than 14 days, which was not appropriate without a Benefits v. Risks (BVR) Review with physician documentation for reasons to continue the PRN Ativan and a recommendation for duration of therapy. CPH B stated CPH A requested a BVR from the physician on 8/2/24, but he did not see a completed BVR after that date. CPH B stated CPH A had also requested a gradual dose reduction of the routine scheduled Ativan on 8/29/24. CPH B stated an order was placed 4/26/24 for Ativan 0.5 mg three times a day (every 8 hours) until 9/6/24 when the order was changed to twice a day (every 12 hours). CPH B stated Resident 61 received three doses of Ativan 0.5 mg (scheduled) and an additional Ativan 0.5 mg (PRN) on 5/23/24 for a total of 2 mg in 24 hours. CPH B stated 2 mg was the maximum (max) recommended dose without a BVR Review by the physician. CPH B stated medication administration records indicated the following: 1. In June 2024, all scheduled Ativan was given three times a day as ordered; an additional four doses of PRN Ativan were given on 6/8, 6/9, 6/13, and 6/14/24. 2. In July 2024, all scheduled Ativan was given three times a day as ordered; an additional two doses of PRN Ativan were given 7/7 and 7/16/24. 3. In August 2024, all scheduled Ativan was given three times a day as ordered; no PRN doses were given. A review of drug information for Ativan on [NAME]-Drug (a drug reference platform that provides information to help medical professionals make evidence-based drug decisions) on 10/15/24 indicated Ativan should be avoided or dose reduced in patients who are receiving opioids or have significant chronic disease. Ativan should be avoided in residents with a history of substance use or depression except for acute or emergent situations like acute agitation or status epilepticus (seizures). Ativan is a high-risk medication and should be avoided in adults aged 65 and older due to increased risk of impaired mental functioning, delirium, falls, and fractures (broken bones). Use of benzodiazepines (drug class) like Ativan is not recommended for greater than or equal to four weeks. Use of Ativan in patients with impaired kidney and liver function may worsen hepatic encephalopathy (a brain disorder that occurs when the liver is unable to remove toxins from the blood, causing them to build up in the brain and impact brain function).

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	056346	A. Building B. Wing	10/08/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43755 Based on observation, interview, and record review, the facility failed to ensure medications and medication supplies were stored and labeled in accordance with currently accepted professional principles when: 1. Two loose pills were found in the drawer of medication cart 2. 2. Six medications that were being dispensed were opened and not dated. 3. Four Foley drainage bags (A bag that collects urine which comes from the bladder through a catheter tube) in a storage room ready for use were expired. 4. Pro-Stat concentrated liquid protein medical food was being dispensed but had expired. These failures had the potential for medication misuse, medication ineffectiveness, and potential exposure to harmful pathogens (bacteria, viruses, fungi) from expired supplies for residents. Findings: 1. During a concurrent observation and interview with the Assistant Director of Nursing (ADON) on 10/2/24 at 10:12 am, an inspection of medication cart 2 was performed. Two loose pills were observed in the middle drawer the medication cart. The ADON confirmed that there should not be loose pills in the cart. 2. During a concurrent observation and interview with Director of Nursing (DON) in the Medication Storage room on 10/01/24 at 11:03 am, two bottles of Tuberculin (a medication uses to test for tuberculosis), and one tube of Muscle Rub Cream were noted to have been opened but were not marked with the date they were opened. DON confirmed it was the policy of the facility that all medications should be dated with the date opened and discarded within 30 days of opening. During a concurrent observation and interview with the ADON on 10/2/24 at 10:12 am, an inspection of medication cart 2 was performed. Two bottles of Enulose (a liquid medication used for liver disease) and a bottle of Geri tussin DM (a liquid medication used for symptoms of cough), that were being dispensed to residents, were noted to have been opened but were not marked with the date they were opened. The ADON confirmed it was the policy of the facility that all medications should be dated with the date opened. 3. During a concurrent observation and interview with DON in the Medication Storage room on 10/01/24 at 11:03 am, four Foley drainage bags were past the expiration date of 3/26/24. The DON confirmed it was the policy of the facility that expired medications or supplies should be discarded and not available for use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent observation and interview with the ADON on 10/2/24 at 10:12 am, an inspection of medication cart 2 was performed. Pro-Stat concentrated liquid protein medical food (a liquid protein used for the dietary management of wounds and other conditions requiring increased protein) was dated opened on 6/30/24 and the storage instructions on the bottle were to discard three months after opening. The ADON confirmed that this protein drink was expired and should have been discarded on 9/30/24. A review of the facility's policy titled Medication Administration General Guidelines (undated), the policy indicated No expired medication will be administered to a resident. The nurse shall place a date opened sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43755 Based on interview and record review, the facility failed to ensure the facility's policy and procedure (P&P) on dental services was followed for one of 22 sampled residents (Resident 35). This failure had the potential to result in Resident 1's weight loss due to difficulty eating. Findings: A review of the facility policy titled Dental Examination/Assessment revised December 2013, indicated Upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist. A review of Resident 35's Admission Record dated 8/27/24, indicated he was readmitted on [DATE] with the diagnoses that included lung disease, depression, left sided paralysis (unable to move his left arm and leg), adult failure to thrive (the feeling of wanting to give up on life), colostomy (a surgical procedure that redirects the colon to an opening in the abdominal wall in which the bowel will exit into a bag), and an indwelling urethral catheter (a tube that goes into the bladder and drains the urine into a collection bag). During a concurrent observation and interview of Resident 35 on 10/1/24 at 3:02 pm, Resident 35 was observed in his room lying in bed. Resident had no teeth in his mouth. Resident 35 stated They (a dentist that came to the facility) pulled them out and now they say they cannot give them (dentures) to me because I do not have insurance. I was eating good with the teeth I had in my mouth, now I cannot chew the bread it is too hard. During an interview on 10/03/24 at 11:36 am, the Social Service Director (SSD) indicated Resident 35 had his teeth extracted on December 8, 2023, by a facility contracted dental service, and impressions and x-rays were done on January 12, 2024. During an interview on 10/3/24 at 11:37 am, the Social Service Assistant (SSA) indicated Resident 35's insurance plan had changed, and the contracted dental services will not honor the new insurance. A review of Resident 35's dental notes from (Dental Name) Healthcare dated 12/08/23, showed Resident 35 had 4 teeth extracted. A review of Resident 35's dental notes from (Dental Name) Healthcare dated 1/12/24, showed Resident 35 had upper and lower impressions taken for new dentures. A review of Resident 35's Care Conference dated 6/2/24, showed notes written by the SSD Daughter also asks that we follow up with his dentures. A review of an e-mail by a Patient Care Coordinator (PCC) from (Dental Name) Healthcare dated 6/13/24, indicated I have called a couple of times to discuss a couple of patients that their denture process is on hold due to their (insurance name). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeview Post Acute	521 Lorel Way Yuba City, CA 95991

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/24 at 1:56 pm, the SSD indicated she had not called the contracted dental services to follow up on Resident 35 dentures until his daughter brought it up at the care conference 5 months after he had his teeth pulled and impressions done. The SSD indicated that she should have followed up on it.

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NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview and record review, the facility failed to prepare and serve food that maintained an appetizing flavor, texture, appearance, and at a palatable (pleasant taste) temperature when 5 of 22 sampled residents (Residents 11, 35, 77, 84, 215) when: 1.Resident 77 stated the food was overcooked and could not even cut it. 2. Resident 84 stated the pork was undercooked, and he had to throw it away. 3. Resident 11's ice cream was served melted. 4. Resident 35's food was served cold, ice cream was served melted, and biscuits were served burnt. 5. Resident 215's pizza was served burnt. These failures resulted in meals to be served overcooked, undercooked, cold, unpleasant, and not meet the resident food preference, which had the potential for residents to decrease meal intakes and have weight loss issues. Findings 1. During a review of Resident 84's clinical record, indicated that Resident 77 was admitted to the facility on [DATE] with diagnoses which included stroke, diabetes (high blood sugar), and hypertension. He was his own healthcare decision maker. During a review of Resident 84's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 7/25/24, indicated Resident 77's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. During an interview on 10/1/24 at 10:20 am with Resident 77, Resident 77 stated that he was the President of the Resident Council (a group of residents in a long-term care facility who meet regularly to discuss concerns, plan activities, and advocate for change), and the problem with the food had been brought up several times, and it had not been solved. Resident 77 stated, For weeks, the sausage was burnt. I couldn't even cut it. The Certified Nursing Assistant (CNA) went down to the kitchen to get a new sausage for me, and it's still burnt. This morning, the gravy was cold. They kept telling me the plate warmer is coming, but it has been 5 months I talked to the Dietary Manager (DM) every month, and nothing got done. 2. During a review of Resident 84's clinical record, indicated that Resident 84 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and hypertension. He was his own healthcare decision maker. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 84's MDS, dated [DATE], indicated Resident 84's cognition was moderately impaired. During an interview on 10/1/24 at 12:21 pm with Resident 84, Resident 84 stated, I don't like this cut up pork. It's almost raw, every time I ate it, I s**t, I just threw it away! 43755 3. A review of Resident 11's Admission Record dated 2/2/24, indicated she was admitted on [DATE] with the diagnoses that included lung disease, dysphagia (difficulty swallowing), depression, and right sided paralysis (not able to move right arm or leg). A review of Resident 11's Quarterly MDS, dated [DATE], indicated Resident 11's Brief Interview for Mental Status (BIMS, evaluates a person's cognition, [ability to think, learn, remember, use judgement, and make decisions] with scores from 00 to 15) score was 15 indicating her cognition was intact and she could make her own decisions. During an interview on 10/1/24 at 12:27 pm, Resident 11 indicated that her ice cream comes melted. She indicated they should take the ice cream around after we get our trays which was around 1:30 pm. During observation of tray line on 10/3/24 at 1:25 pm, ice cream on resident trays in the last food cart appeared soft. On squeezing a plastic ice cream cup, both sides were easily pushed in, indicating the ice cream was not frozen. 4. A review of Resident 35's Admission Record dated 8/27/24, indicated he was admitted on [DATE] with the diagnoses that included lung disease, depression, left sided paralysis, and adult failure to thrive (the feeling of wanting to give up on life). A review of Resident 35's Yearly MDS dated [DATE], indicated Resident 35's BIMS score was 15 indicating his cognition was intact and he could make his own decisions. During an interview on 10/1/24 at 3:01 pm, Resident 35 indicated that his food was always cold, his ice cream comes melted and his biscuits were burnt this morning. He stated the smell is making me sick. Resident 35 indicated he had told the CNA's these concerns. During an interview with the Dietary Manager (DM) on 10/3/24 at 3:26 pm, the DM indicated they had just got a new plate warmer today (10/3/24) because the previous plate warmer did not keep the plates hot enough to keep the food warm. The DM said there had been complaints about the food being cold. During an interview on 10/1/24 at 3:44 pm, CNA K indicated the food carts come out late and the residents have told me that the food is cold, so I warm it up for them. 5. A review of Resident 215's Admission Record dated 9/9/24, indicated she was admitted on [DATE] with the diagnoses that included lung disease, muscle weakness, and depression. She was her own responsible party (RP, she made her own decisions concerning her care). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 215's Admission MDS dated [DATE], indicated Resident BIMS score was 15 indicating her cognition was intact. During an observation and interview on 10/3/24 at 1:44 pm, Resident 215 was observed eating her lunch in her room. Resident 215 held up the pizza she was eating that had come on her tray. The bottom of the pizza was black and hard. Resident indicated that the pizza was burnt, and she did not like it that way but suffered through eating it that way anyway. CNA F confirmed the pizza was burnt and should not have been served that way. 49418 During initial kitchen tour on 10/1/24 at 9:03 pm, observed an unused plate warmer present in the dry storage room. Observed a piece of paper titled Meal Times posted on the wall indicating breakfast was served at 7 am, lunch at 12 pm, and dinner at 5 pm. During an interview with Dietary Manager (DM) on 10/2/24 at 5:53 am, DM stated the plate warmer in the dry storage room was new and had not been used yet but had metal bases that would keep food warmer for longer. DM stated she requested the purchase because the old warmer didn't keep food hot enough. DM stated resident complaints used to be palatability and taste, but that went away when COOK 2 was hired in August. DM stated, It's just temperature now, complaints about food not warm enough. DM stated that would be fixed with the new plate warmer. During observation of tray-line food preparation on 10/3/24 at 11:35 am, observed COOK 1 remove multiple pizzas from the oven. Pizzas were placed on surfaces without a heat source. Observed COOK 1 attempting to slice one pizza with difficulty; observed the pizza crust to be dark brown on the bottom. The pizza was sliced and placed on plates by COOK 1 for distribution to residents. Food carts were loaded with resident trays. Cart 1 left the kitchen at 12:21 pm, Cart 2 at 12:35 pm, Cart 3 at 12:53 pm, and Cart 4 at 1:20 pm. During concurrent kitchen observation and interview with DM on 10/3/24 at 1:25 pm, observed a chart posted which indicated which room numbers received food deliveries from Carts 1 through 4. DM stated carts go out in order, 1 through 4. DM stated they stick to that [schedule] unless there's COVID. When asked if 90 minutes from first tray to last tray was normal, DM stated they were doing great if tray line started at noon and last trays were delivered before 1:30 pm. During concurrent test tray observation/tasting and interview with Certified Dietary Manager (CDM) on 10/3/24 at 1:30 pm, pizza slice temperature taken with CDM's food thermometer indicated 95 degrees. CDM stated, Ideally, the temperature should be over 135 degrees for proper service of hot food. After tasting the pizza, CDM acknowledged the temperature was lukewarm. CDM acknowledged seeing the pizza with a dark brown crust and stated it should not have been served to residents. CDM stated a solution to cold food complaints could be to cook pizza in stages so it could be served hot and to rotate tray cart delivery times to prevent the same residents from getting the last food trays. During an interview with Social Services Assistant (SSA) on 10/4/24 at 11:41 am, SSA stated the DM listens to criticisms about food, responds well, and will talk to residents about concerns. SSA stated DM is overwhelmed with hearing about all the complaints. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of policy and procedure (P&P) titled Food: Preparation, dated 9/2017, indicated the Dining Services Director/Cook(s) were responsible for food preparation techniques which minimize the time food items are exposed to temperatures greater than 41 degrees and/or less than 135 degrees, or per state regulation. All foods will be held at appropriate temperatures, greater than 135 degrees (or as state regulation requires) for hot holding and less than 41 degrees for cold food holding. A review of P&P titled Meal Distribution: Infection Control Considerations, dated 9/2017, indicated (1) all meals will be assembled in accordance with individualized diet orders, plan of care, and preferences, and . (3) all food items will be transported promptly for appropriate temperature maintenance.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315 Based on observation, interview, and record review, the facility failed to honor food preferences for five out of 22 sampled residents (Residents 46, 90, 100, 104, and 106) when: 1. Resident 46 received eggs for breakfast. 2. Resident 90 received rice with meals. 3. Resident 100 received tomatoes with a salad. 4. Resident 106 received eggs for breakfast and a tuna fish sandwich for lunch. 5. Resident 104 received carrots, peas, and corn with meals. This failure had the potential to negatively impact psychosocial health and cause weight loss. Findings: 1. A review of the facility's policy and procedure (P&P) titled, Dining and Food Preferences, revised 9/1/17, indicated, resident food preferences would be reviewed, documented, and an alternate meal substitution would be provided. A review of the Resident Council meeting notes, dated 7/23/24, indicated, food complaints from the previous meeting held in June, had not been resolved. The meeting notes did not indicate, what the food complaints were. During a review of the undated, COVID-19 Resident Satisfaction Survey, that was provided with Resident Council meeting notes, dated 9/24/24, indicated, the food could use some help. The document did not indicate what the food complaint was. A review of the undated Admissions Record, indicated, Resident 46 was admitted to the facility on [DATE] with the diagnoses of type 2 diabetes (inability to regulate blood sugar levels because the body didn't produce enough insulin) and anxiety. Resident was her own responsible party (RP, made own decisions) A review of Resident 46's Quarterly Minimum Data Set (MDS, an assessment tool), dated 9/17/24, indicated, a Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) had been performed. Resident 46 had a BIMS of 15, which indicated good memory. During an interview on 10/2/24 at 8:38 am, Resident 46 stated, the food that was served in the facility was a work in progress. Resident 46 stated, in the past, Resident 46 reported the dislike of eggs to an unknown female staff member and continued to receive eggs for breakfast. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 46's Dietary Profile dated 9/18/24, did not include eggs as a dislike. 2. A review of the undated Admissions Record, indicated Resident 90 was admitted to the facility on [DATE] with the diagnoses of type 2 diabetes and high blood pressure. Resident 90 was his own RP. A review of Resident 90's Quarterly MDS, dated [DATE], indicated, Resident 90 had good cognition and a BIMS score of 15. During an interview on 10/2/24 at 11:02 am, Resident 90 stated, the facility did not honor food preferences. Resident 90 stated having a dislike of rice and was served rice often. A review of Resident 90's Dietary Profile, dated 1/24/24, 4/24/24, and 7/18/24, indicated, Resident 90 did not like rice. 3. A review of Resident 100's undated Admissions Record, indicated, admission to the facility on [DATE] with the diagnoses of heart failure and depression. Resident 100 was her own RP. A review of Resident 100's Quarterly MDS, dated [DATE], indicated, Resident 100 had good cognition and a BIMS score of 15. During an interview on 10/1/24 at 11:24 am, Resident 100 stated, the food is terrible, I don't eat tomatoes, and they always serve me tomatoes. Resident 100 stated, when you complain about the food, the food is worse, like they intentionally give us food we don't like. During a concurrent observation, interview, and record review, on 10/1/24 at 1:25 pm, Resident 100's lunch tray was observed. Resident 100 stated, there were tomatoes served with lunch. A salad that contained pieces of cut up tomatoes was observed next to a meal tray ticket. The meal tray ticket, dated 10/1/24, indicated, Resident 100 disliked tomato products. The facility's Infection Preventionist (IP) was unaware which staff member had checked the resident's meals for accuracy and confirmed, Resident 100 disliked tomatoes and confirmed Resident 100 received tomatoes with her lunch. 4. A review of the undated Admission Record, indicated, Resident 106 was admitted to the facility on [DATE] with the diagnosis of dysphagia following nontraumatic intracerebral hemorrhage (bleeding in the brain that caused difficulty with swallowing and was not caused by injury). Resident 106 was not her own responsible party (did not make own decisions). A review of Resident 106's Quarterly MDS, dated [DATE], indicated, Resident 106 had a BIMS score of 3, which indicated poor memory. During an interview on 10/1/24 at 12:35 pm, Resident 106 stated, the food was bad, did not eat the amount of food that Resident 106 would normally eat, felt worthless, and began to cry. During a concurrent observation and interview on 10/1/24 at 1:33 pm, Resident 106 was observed eating fast food with family member (FM). Resident 106 stated, lunch was horrible. FM stated, FM brought food to Resident 106 due to not liking the lunch that was served. Resident 106 stated, lunch was a tuna fish sandwich and disliked tuna. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 521 Lorel Way, Yuba City, CA 95991	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with the facility's Director of Staff Development (DSD), the cart that contained resident meal trays was observed. DSD found the lunch tray that was served to Resident 106. DSD stated, the meal tray ticket, dated 10/1/24, located on the meal tray, indicated, Resident 106 disliked fish and confirmed, Resident 106 was served a tuna fish sandwich for lunch. During a concurrent observation and interview, on 10/3/24 at 8:31 am, located in Resident 106's room, there was no breakfast tray present. Resident 106 stated, I was served an egg and cheese omelet this morning and they know I don't like eggs, so I didn't eat it. Certified Nurse Assistant (CNA) B arrived and provided Resident 106 with an alternate breakfast. When CNA B removed the lid from the plate, a piece of bacon and an egg and cheese omelet was observed. CNA B stated unawareness that Resident 106 did not like eggs, CNA B walked to the breakfast tray cart and found Resident 106's original breakfast tray, observed an egg and cheese omelet on the plate, and reviewed the meal tray ticket. CNA B confirmed, the meal tray ticket indicated, Resident 106 disliked eggs, was provided an egg and cheese omelet for breakfast, and the alternate meal provided, consisted of an egg and cheese omelet. During an interview on 10/3/24 at 8:50 am, Licensed Nurse (LN) C stated, the LNs were responsible for performing a visual inspection of the meal trays prior to the resident being served their meals. LN C stated, the reason the LN's checked the meal trays was to ensure residents received the correct meal texture, the correct adaptive equipment (utensils, plates, cups), and that the meal did not include foods that the resident did not like. LN C stated, being responsible for checking Resident 106's breakfast tray and stated, LN C was in a hurry and did not review the breakfast trays for resident food preferences. LN C confirmed, Resident 106 was served an egg and cheese omelet and did not like eggs. During a concurrent interview and record review on 10/3/24 at 9:16 am, with Certified Dietary Manager (CDM) and Dietary Manager (DM), photos of Resident 106's breakfast and alternate breakfast were reviewed. CMD and DM confirmed, Resident 106 was served an egg and cheese omelet for breakfast and as an alternate meal. CDM and DM acknowledged there were resident concerns regarding food preferences not being honored. 49418 5. During an interview with Resident 104 on 10/2/24 at 10:26 am, Resident 104 stated, Yuck, when asked about the food served in the facility. Resident 104 stated they often request hamburgers and hot dogs rather than the meals offered and that the vegetables are always overcooked. Resident 104 stated they do not want carrots, peas, or corn but, I'm always getting those. Resident 104 also stated kitchen staff chop the spinach too small and overcook it. A review of Resident 104's Thursday Breakfast and Thursday Lunch food tray tickets, dated 10/3/24, indicated dislikes include carrots, corn, peas, and spinach. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Dietary Manager (DM) on 10/2/24 at 5:53 am, DM stated she and Registered Dietitian (RD) work together to ask residents their food preferences. DM acknowledged two (unnamed) residents complained about receiving foods on their dislikes lists on 10/1/24, and the residents should not have received those items. DM stated, Corporate controls what options are available, noting one resident likes lettuce but not tomatoes, but lettuce and tomato are together on the preference list. DM acknowledged a resident whose documented dislikes included no fish groups should not have received a tuna sandwich on 10/1/24, and the other resident should not have been served a tomato on her sandwich but the kitchen was rushed with State [surveyors] present in the building.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49418 Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation requirements were met in accordance with professional standards for food service safety when: 1. Food was not properly stored, labeled and dated, with expired food items present in kitchen refrigerator/freezers. 2. Kitchen and food service equipment was not in sanitary condition; 3. The kitchen environment was not in sanitary condition; 4. Resident food was not stored or labeled per policy and procedure (P&P) in the resident refrigerator/freezer, and the refrigerator was visibly dirty inside. These failures created the potential risk for exposure to food- and waterborne illnesses in a medically vulnerable population of 105 residents who receive food stored and prepared in the facility. Findings: 1. A review of P&P titled Refrigerators and Freezers, dated ,d+[DATE], indicated the facility will: A. Ensure safe refrigerator/freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. B. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. C. Use by dates will be completed with expiration dates on all prepared food in refrigerators. D. Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. A review of the 2022 Food Code, United States (US) Food and Drug Administration (FDA), ,d+[DATE].17, Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking indicated: Except when packaging food using reduced-oxygen packaging methods (vacuum-sealed), refrigerated, ready-to-eat foods prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit (F - a unit of measure) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. During observation on initial kitchen tour on [DATE] at 9:03 am, observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. An open jar of applesauce in Refrigerator 2 labeled use by date of [DATE]. B. A foil-covered metal container in Refrigerator 1 labeled Puree bread made [DATE] with no use by date. C. A Ziplock bag contained seven boiled eggs in Refrigerator 2 with no label/dates. D. An open container of curry powder indicated use by date of [DATE]. E. The label for an open container of ground rosemary was peeled off; no opened/use by dates were seen. F. Two open, unsealed, undated bags of sliced bread in dry storage area. G. A bag of unused cocoa powder with a small hole in the seam, with cocoa powder spilling onto food storage shelving. H. The top rack of the walk-in refrigerator contained an undated prepackaged meat and cheese sandwich together with a grocery store plastic bag with undated food items. I. An egg in Refrigerator 2 with dried, yellow, yolk-like substance on the shell. During a concurrent observational kitchen tour and interview with Registered Dietitian (RD) on [DATE] at 9:53 am, RD acknowledged the hole in the cocoa powder bag had been there for an unknown length of time and may allow bacteria or pests to enter the bag. RD acknowledged food items should be discarded if packaging was compromised. RD stated the open bread bag should have been closed and labeled with an opened on date. During concurrent observational kitchen tour and interview with COOK 2 on [DATE] at 9:29 am, COOK 2 stated facility policy for foods stored in refrigerators and freezers is first in, first out, indicating foods received or opened first should be used before using/opening other items. COOK 2 stated staff are supposed to write an opened on date on food items but she sometimes forgets. During a concurrent observation of the kitchen and interview with Dietary Manager (DM) on [DATE] at 5:53 am, DM stated the expired applesauce in Refrigerator 2 was not labeled correctly. DM stated it should have been dated to expire [DATE], four days after the opened date of [DATE]. DM acknowledged the egg with yellow substance on its shell was an infection control issue and should have been discarded, and the bag of boiled eggs should have been dated. DM stated the prepackaged sandwich was a staff members lunch and acknowledged staff food should not be stored with resident food. Observed an open bag of bread crusts, undated, on dry storage shelves. DM acknowledged the bag should have been tied closed and dated. During an interview with COOK 2 on [DATE] at 11:35 am, when discussing cooling and reheating measures for cooked/prepared foods, COOK 2 stated, We cook to serve. We don't do leftovers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. A review of P&P Meal Distribution: Infection Control Considerations, dated ,d+[DATE], the P&P indicated meal service and ware washing (washing of dishware and utensils) for residents with infectious conditions will follow the guidelines of the Federal Center for Disease Control (CDC) or as directed by the local or state health officials. A review of the 2022 Food Code, US FDA, ,d+[DATE].11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils indicated: A. Equipment food-contact surfaces and utensils shall be clean to sight and touch. B. The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. C. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. A review of Job Description, [NAME] (undated) indicated the cook prepares food in accordance with current applicable federal, state, and local standards, guidelines, and regulations, in line with established facility P&Ps, to ensure quality dining services are provided at all times. The cook assists in assuring proper receiving, storage, preparation, serving, sanitation, and cleaning procedures are followed. The cook must assist dietary aides (DAs) as necessary and supervises DAs in the preparation and serving of foods and beverages. The cook follows posted cleaning schedules utilizing proper sanitation and cleaning methods, cleans food preparation and utensils after use and meal service, and is responsible for washing dishes and cleaning the kitchen to keep it sanitary and up to health standards. A review of Job Description, Dietary Aide (DA) (undated) indicated DAs assist the cook in preparation and service of meals. DAs prepare and deliver food and trays, wash dishes, and clean and sanitize the kitchen according to health standards, ensuring cleaning schedules are followed using proper sanitation and cleaning methods. DAs clean food preparation areas and utensils after use and meal service and are responsible for washing dishes and cleaning the kitchen to keep it sanitary and up to health standards. A review of Concern/Grievance Log indicated a resident complaint on [DATE] for food portions and cleanliness of drinkware. Staff assigned to follow up the complaint were the Administrator, DM, and Director of Nursing. The plan of action was to do in-service for staff. A review of Inservice/Meeting Sign in Sheet, dated [DATE], indicated an in-service was held by instructors CDM and DM and covered job descriptions, professionalism, cleanliness, and tray cards. COOK 1, COOK 2, DA I, DA J, and DA K were among those in attendance. During initial observational kitchen tour on [DATE] at 9:03 am, observed: A. Thick, black, crusty debris and food particles under stovetop burners. B. A brown, greasy-appearing substance splattered on the stove backsplash. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation of the kitchen and interview with Dietary Manager (DM) on [DATE] at 5:53 am, DM stated discussed missing dish station log entries on [DATE] with CDM. DM stated one shift was a disaster and she was frustrated. DM stated she had just educated staff on log entries, but certain staff needed frequent re-education. DM acknowledged stovetop and ovens were not clean and were an infection control issue. Observed residue on the can opener blade. DM acknowledged it was not clean and sent it through the dishwasher. A knife removed from the knife holder revealed a dried piece of lettuce stuck to the blade. Food crumbs were present on top of the knife holder. DM acknowledged the soiled knives and knife holder to be an infection risk, noting the wall-mounted knife holder would need to be removed by maintenance for sanitizing due to the potential for knives to be repeatedly exposed to bacteria. Observation of the steamer indicated a moist brown residue along the door seal. DM wiped a white sanitizing cloth across the area; brown residue was observed on the cloth. DM acknowledged the steamer was not clean and was an infection control issue. Asked about the dishwasher, DM stated Ecolab presets the sanitizer levels to be delivered to the dishwasher and three-compartment sink. Informed DM that the third sink quaternary level was 500 ppm on [DATE], DM stated, That's too much. DM stated the contracted supplier sets. During concurrent kitchen observation and interview with Certified Dietary Manager (CDM) on [DATE] at 11 am, CDM tested a red bucket containing sanitizing solution of water and quaternary ammonium to reveal quaternary strength of 150 ppm. CDM stated the sanitizer solution was used to sanitize kitchen surfaces and equipment and should be between 200 and 400 ppm to be effective. CDM acknowledged 150 ppm would not be sufficient to sanitize as it may not kill all bacteria. Discussed that quaternary test strip showed 500 ppm at three-compartment sink on [DATE], and CDM stated a quaternary strength over 400 ppm was a waste of product . It goes inert after a time. During concurrent observation of tray line and interview with Dietary Aide I (DA I) on [DATE] at 11:05 am, observed a shallow plastic container of juice cups covered with plastic lids. Ice cubes were observed on several lids and on the bottom of the container. DA I stated she placed ice over the drink lids to keep it cold, then placed the cart in the refrigerator until ready to serve. During concurrent observation of walk-in refrigerator and interview with CDM on [DATE] at 11:10 am, observed a rolling food cart filled with multiple trays of uncovered cups of fruit cocktail. CDM acknowledged food in the refrigerator should be covered to avoid infection risk, and ice should not be placed on top of beverage cups as it can water down the beverage. During an interview with DM on [DATE] at 11:30 am, DM stated it was an individual choice and not good to put ice on beverage cups to keep them cold. During kitchen observation of tray line on [DATE], observed the microwave interior at 11:55 am to reveal moist tan food residue spilled on the bottom and dripped onto the microwave table below it. At 1:15 pm, observed DM remove several utensils with food particles stuck to them from clean silverware containers. DM asked CDM to rewash the utensils and bring clean silverware for resident trays. DM acknowledged the utensils were not clean, which was an infection risk. At 1:25, asked DA K to open the microwave; the spill was still present (90 minutes later). DA K and CDM acknowledged food should be removed immediately after heating and spills cleaned when they happen. DA K and CDM acknowledged the microwave posed a risk for contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. A review of P&P titled Environment, dated ,d+[DATE], indicated all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary manner and all food contact surfaces will be cleaned and sanitized after use. The P&P indicated the Dining Services Director will ensure: A. The kitchen is maintained in a clean and sanitary manner including floors, walls, ceilings, lighting, and ventilation; B. All employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces; and C. A routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. A review of the 2022 Food Code, US FDA, indicated: A. ,d+[DATE].13, Nonfood-Contact Surfaces: The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms, which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. B. ,d+[DATE].15, System Maintained in Good Repair: Improper repair or maintenance of any portion of the plumbing system may result in potential health hazards such as cross connections, backflow, or leakage. These conditions may result in the contamination of food, equipment, utensils, linens, or single-service or single-use articles. Improper repair or maintenance may result in the creation of obnoxious odors or nuisances and may also adversely affect the operation of ware washing equipment or other equipment which depends on sufficient volume and pressure to perform its intended functions. C. ,d+[DATE].12, Cleaning, Frequency and Restrictions: (1) Physical facilities shall be cleaned as often as necessary to keep them clean, and (2) except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of food is exposed, such as after closing. D. ,d+[DATE].14, Cleaning Ventilation Systems, Nuisance and Discharge Prohibition: Intake and exhaust air ducts shall be cleaned, and filters changed so they are not a source of contamination by dust, dirt, and other materials. During concurrent observation on initial kitchen tour and interview with COOK 2 on [DATE] at 9:03 am, COOK 2 stated the kitchen is often disgusting on arrival in the morning with food in the sinks, and garbage disposals smell like something died . Observation revealed: A. Kitchen floor with food crumbs, dried gray drip marks, food crumbs and spills between ovens, and a dinner roll under one oven. (continued on next page)

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